Central West **LHIN**

Annual Business Plan 2015/16

Central West Local Health Integration Network

April 2015

Ontario
Local Health Integration Network

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A Message from the Board Chair and CEO

The Central West Local Health Integration Network (LHIN) is pleased to present its 2015/16 Annual Business Plan (ABP 2015/16) for the fiscal year beginning April 1, 2015 and ending March 31, 2016.

Each year the LHIN develops a formal business plan that outlines the allocation of resources designed to support the overall implementation of its three-year strategic plan, more commonly referred to as the *Integrated Health Service Plan* (IHSP). ABP 2015/16 represents the priorities for the third and final year of the LHIN's current IHSP 3.

While the LHIN's strategic directions are shaped by provincial priorities, ABP 2015/16 reflects local initiatives. It describes how, in collaboration with Health Service Providers (HSPs) and community partners, the Central West LHIN will provide Better Health, Better Care, and Better Value for local residents.

Highlighted are specific activities that align to each of the Central West LHIN's four strategic directions and corresponding initiatives identified in IHSP 3 including *Improve Access to Care, Streamline Transitions and Navigation of the System, Drive Quality and Value, and Build on the Momentum*. Attention is given to the current status of each initiative; activities to be completed during the coming fiscal year; the impact that these initiatives/activities will have on the local health care system; and performance measures that will be used to gauge LHIN success. In addition, ABP 2015/16 includes an overview of plans related to operations (finance and staffing) and communications/community engagement.

As indicated, 2015/16 marks the third and final year of the Central West LHIN's current IHSP 3. With *Patients First* – Ontario's Action Plan for Health Care and *Ministers' Mandate Letters* of September 2014 acting as a foundation, the LHIN will begin the important process of planning and designing its strategic goals and objectives for the next three years...IHSP 4. As an organization, the Central West LHIN remains committed to ensuring residents receive the right care, at the right time and in the right place; that the local health care system remains accountable, efficient and transparent; and, to promoting healthier lifestyles for local residents through shared responsibility.

Both residents and health care professionals place a high value on their health care system and its need to be responsive to local communities. The LHIN's Board of Directors and staff thank HSPs and community partners who have taken ownership and accountability for meaningful change, and local residents who continue to play an active role in shaping their local health care system. Collectively, this ongoing dedication and commitment toward the provision of high-quality patient-centred health care is transforming a bold vision into reality.

Together, we are making healthy change happen!

Maria Britto
Board Chair, Central West LHIN

Scott McLeod
Chief Executive Officer, Central West LHIN

OVERVIEW | ABP 2015/16

ABP 2015/16 is the Central West Local Health Integration Network (LHIN) work plan for fiscal year beginning April 1, 2015 and ending March 31, 2016. It outlines key activities the LHIN will undertake to implement the strategic directions and initiatives outlined in the third and final year of its current Integrated Health Service Plan (IHSP 3). An extension of IHSP 3, ABP 2015/16 indicates how, in collaboration with local Health Service Providers (HSPs) and the broader health care sector, the LHIN will work to improve the health of residents who live within the geographic boundaries of the Central West LHIN.

ABP 2015/16 is divided into four main sections:

- **Section 1 | Context** - provides an overview of the Central West LHIN's mandate, strategic directions and alignment with Ministers' Mandate Letters; Ministry of Health and Long-Term Care (MOHLTC) and pan-LHIN priorities; an environmental profile of local residents; a summary of current activities; and an assessment of potential challenges to the local health care system.

- **Section 2 | Healthy Change in Action** - outlines the work the Central West LHIN will undertake in 2015/16 to support the strategic directions of IHSP 3; describes the performance measures and targets that will be used to measure progress; and, reviews potential risks/barriers to successful implementation.

  *** As per MOHLTC guidelines, the status of work (Not yet started, In progress, Deferred or Completed) is indicated as a percentage of completion anticipated over the next three years. "Ongoing" refers to work which, while being completed or complete, will continue to various degrees in subsequent years.*

- **Section 3 | Financial Plan, Staffing and Operations**... provides a three-year spending plan for Central West LHIN Operations including a summary of current and proposed staffing levels.

- **Section 4 | Communications and Community Engagement**... describes Central West LHIN goals, objectives and evaluation measures as they relate to communications & community engagement during the coming fiscal year.

The success of ABP 2015/16 will be documented in the Central West LHIN's Annual Report which looks back on work accomplished, chronicling how its activities are enabling delivery of the right care, in the right place and at the right time for local residents.

In partnership with the MOHLTC, HSPs, community partners and local residents, the Central West LHIN is working to ensure a sustainable, high-quality and person-centred local health care system for current and future generations.

SECTION 1 | Context

1.1 LHIN Mandate, Strategic Directions and Alignment

The Central West Local Health Integration Network (LHIN) was established under the *Local Health System Integration Act (LHSIA) - 2006* and given the authority to plan, integrate, fund and monitor the local health care system for the purpose of improving the health of residents who live in communities within its geographic boundaries. Given its mandate, the LHIN has established a set of principles to guide its planning process:

Central West LHIN - Guiding Principles

- Equitable access based on patient/client need
- Preservation of patient/client choice
- People-centred, community-focused care that responds to local population health needs
- Measureable, results-driven outcomes based on strategic policy formulation, business planning and information management
- Shared accountability between providers, government, community and citizens

The following strategic directions and accompanying initiatives, outlined in IHSP 3, will guide this year's activities:

Improve Access to Care

- Primary Health / Family Health Care
- Chronic disease prevention & management programs
- Mental health and addictions services
- Community-based services for seniors

Streamline Transitions & Navigation

- Improve linkages with and among Primary Health / Family Health Care and other providers in the health system
- Improve system navigation resources
- Increase system collaboration through use of information technologies

Drive Quality & Value

- Ensure an overarching LHIN quality framework
- Optimize use of health care resources to foster better care

Build on the Momentum

- Aboriginal Health
- Diversity and Health Equity
- French language Services
- Palliative Care
- Women and Children's Health

To support the Central West LHIN's vision – to create a health care system that helps people stay healthy, delivers good care when people need it and that will be there for our children and grandchildren - the Central West LHIN's strategic directions identified in IHSP 3 align with Ontario's original Action Plan for Health Care, and also pan-LHIN system imperatives.

Ontario's (original) Action Plan for Health Care	Central West LHIN's IHSP 3: 2013-2016	Pan-LHIN System Imperatives
Keeping Ontario Healthy	Drive Quality and Value	Leading with quality and safety
Faster access to stronger primary health care	**Improve Access to Care**	Strengthening and enhancing access to primary care
Right Care, Right Time, Right Place	Streamline Transitions & Navigation	Enhancing coordination and transitions of care for targeted populations
	Build on the Momentum	Holding the gains

ABP 2015/16 also takes into account the objectives identified in Patients First – Ontario's Action Plan for Health care and priorities confirmed in *Ministers' Mandate Letters* issued in September 2014 by the Premier of Ontario to the Minister of Health and Long-Term Care and Associate Minister of Health and Long-Term Care: Long-Term Care and Wellness. Inclusion of these priorities into the planning process ensures the Central West LHIN remains mindful of three important goals: residents receive the right care, at the right time and in the right place; the local health care system is accountable, efficient and transparent; and, healthier lifestyles are promoted for local LHIN residents through shared responsibility.

1.2 The Landscape: Environmental Scan of LHIN Residents

Population Profile

The Central West LHIN is home to approximately 870,000 residents, comprising six percent of Ontario's total population. The population is predominantly urban with 86% of residents residing in urban centres and the remaining 14% living in mixed urban/rural (8%) and rural communities (6%). The LHIN has one of the highest population growth rates in the province. Between 2006 and 2011, the number of residents increased by 11%, compared to 6% across the province. This growth is projected to continue, climbing another 10% over the next 7 years to 960,000 residents by 2021.

The LHIN currently has the lowest proportion of senior residents among the 14 LHINs, with the population aged 65 and over comprising 11% of the total population, compared to 14% in Ontario. While seniors in the LHIN appear to be healthy with high life expectancy, low crude mortality and a lower prevalence of all major chronic diseases, estimates project that the LHIN will experience unprecedented growth in its senior population, rising 52% by 2022 compared to 43% growth predicted for Ontario. The fastest growing age group is those 65 to 74 years of age, with a projected increase of 38% by 2022.

The LHIN is also one of the most diverse communities in the province, with over half of local residents belonging to a recognized visible minority group (Ontario: 26%). Almost half of the population within the LHIN are immigrants (47%) and 13% of residents are newcomers to Canada within the past five years. 58% of LHIN residents report English as their mother tongue and four percent report no knowledge of either official language - the second highest rate in the province. The LHIN is home to over 16,000 Francophones and 5,600 residents who self-report as Aboriginal people.

Health Profile

36% of adults residing within the LHIN have one chronic condition. 14% have multiple chronic conditions; 52% are overweight or obese and 58% are physically inactive. The LHIN has the second highest prevalence rate of diabetes in Ontario comprising 14% of the total population. The LHIN has had the highest percentage change in prevalence of diabetes (2.4%) between 2009 and 2013. Compared to other LHINs, the prevalence of diabetes for patients aged 70 and over is the highest in the province. 34% of Central West LHIN residents living with diabetes received blood sugar, "bad" cholesterol, and retinal exam tests within recommended guideline periods, which was slightly lower than the provincial average of 35%.

Mental health and addictions are a growing concern for LHIN residents. The LHIN has experienced an increased number of emergency department (ED) visits, acute hospitalizations and re-visits for mental health and substance abuse over the past several years, particularly among youth aged 12-24 years. The rate of visits to a Health Service Provider (HSP) for mental health and addictions is significantly higher than the provincial average (22% vs. 14%), and median wait times for community support services, case management, counseling/treatment, early intervention programs and supportive housing continue to exceed those in neighbouring LHINs.

The Central West LHIN has five Health Links in place, which cover the entire geographic area of the LHIN. Each Health Link will ensure complex high needs patients receive better coordinated care through tightly knit teams of providers. Driving the implementation of Health Links will continue to be a key focus of the LHIN's activities in 2015/16.

Meanwhile, rates among specific disease groups are improving. Chronic Obstructive Pulmonary Disease (COPD), heart disease and stroke are among the lowest in the province. Mortality rates for arthritis, cancer, COPD, hypertension and Ischemic Heart Disease are also among the lowest in Ontario. With the exception of arthritis, all chronic conditions are decreasing and the percentage of LHIN residents over 75 years of age with heart disease is lower than the Ontario average.

In 2013-14 the LHIN conducted its latest public (local resident) poll. According to results, there has been a steady increase, over the past seven years, in the number of residents who are satisfied with access to their local health care programs and services. An increasing number of local Central West LHIN residents feel their health care has changed for the better, including access to and quality of local health care services. Noticeably, 88% of residents indicated satisfaction with the quality of their local health care in the Central West LHIN, an 11% improvement over the previous public poll conducted in 2009.

This is the third such poll in seven years, an indication of the importance placed by the LHIN on the ongoing assessment of local residents' satisfaction with their health services, their confidence in the health care system and their views of local health priorities.

1.3 Current Programs and Activities in the Central West LHIN

Health Service Providers

Through a budget of $871 million, provided by the Ontario Ministry of Health and Long-Term Care (MOHLTC), the Central West LHIN funds Health Service Providers (HSPs) and community partners in the regions of Brampton, Caledon, Dufferin, Malton, north Etobicoke and west Woodbridge.

- 2 hospital corporations, operating 3 hospital sites attending over 70,000 hospital admissions and 233,500 unscheduled emergency department visits/year
- 1 Community Care Access Centre (CCAC) serving 32,500 clients/year
- 23 Long-Term Care Homes (LTC) providing an estimated 750,000 resident days/year
- 2 Community Health Centres (CHC), operating 5 locations delivering over 25,000 primary care visits/year
- 14 agencies offering community support services (CSS) to an estimated 40,000 clients/year
- 8 mental health and addictions organizations that provide over 20,000 interactions to local LHIN residents each year.

Service Accountability Agreements (SAAs)	Funded	Base Funding	% of LHIN Funding
Acute Care Hospitals	2	$534,293,438	61.3%
Community Care Access Centres (CCACs)	1	$111,366,341	12.8%
Community Health Centres (CHCs)	2	$ 12,399,056	1.4%
Community Support Services (CSS)	14	$23,809,315	2.7%
Long-Term Care Homes (LTC)	23	$154,298,662	17.8%
Mental Health and Addictions Services	8	$ 34,796,221	4.0%

1.4 Areas of Opportunity

Home and Community Care

In 2014/15, the Central West LHIN commissioned the completion of a Community Capacity Study of services for seniors. Guided by the study's recommendations and aligned with Dr. Sinha's "*Living Longer, Living Well*" report, recommendations to inform a seniors strategy for Ontario, and *Ontario's Action Plan for Health Care*, the LHIN will continue to support seniors in the community through targeting of discretionary funding towards identified service gaps in community care. Special attention will be given to strengthening end-of-life care and increasing dementia supports through a refocusing of the *Central West Palliative Care Network*, the development of new memory clinics and the integration of psychogeriatrics into seniors programs. Along with local providers, the work of the Expert Group on Home and Community Care will guide the LHIN to develop, implement and evaluate an integrated acute and poste acute home care model for selected conditions.

In accordance with the provincial LTC redevelopment strategy, the Central West LHIN will implement a multi-year prioritized redevelopment schedule as a strategy to mitigate the impact of temporary bed loss during renovations. This becomes increasingly important considering the number of new LTC referrals made to homes each month continues to exceed the number of beds placed. With 90th percentile wait times for basic accommodation approaching or exceeding 2 years in 65% of funded homes, even the temporary loss of a select few beds can have detrimental effects on timely access to services. LTC homes continue to be challenged in accommodating hard-to-place clients with behavioural barriers; a contributing factor to Alternative Level of Care (ALC) days in LHIN hospitals.

Complex High Needs Patients

In support of Health Links, the Central West LHIN will continue to identify complex high needs patients and work to ensure they have a patient-centred, integrated, coordinated care plan, developed to simplify transitions across sectors and facilitate the navigation of the local health system. Improved access to chronic disease management programs including Telehomecare will be a point of emphasis as the LHIN aims to support the transition of institutional Quality-Based Procedures (QBPs) into the community setting.

In partnership with local HSPs the Central West LHIN is working to integrate Mental Health and Addictions and end-of-life services within Health Links to streamline care coordination among primary care and specialized community-based programs. This will ensure complex patients are placed at the centre of care with all the necessary services wrapped around them by the most appropriate coordinator. The LHIN will leverage existing human health resources by making best use of the skills and capacity of all providers to ensure appropriate care is delivered as close to home as possible.

Vital to the success of a truly integrated health system is the unrestricted and secure access to information within the circle of care. The Central West LHIN will foster relationships with community partners to create a culture of information sharing among service providers while exploiting the capabilities of information technology to support the patient-centred agenda including the implementation of the electronic Care Coordination Tool (CCT) within each of the five Health Links in the LHIN.

Integration of Value for Money and Quality

At a time in which increases in health care expenditures need to be minimized, links must be developed between quality, value-for-money and health system performance. The Central West LHIN is dedicated to achieving greater accountability for results and more transparency in decision making processes. Investing wisely in initiatives that strengthen community health services in the Central West LHIN requires a level of fiscal prudence that ensures identified programs receive the right funding accompanied by accurate and reflective performance obligations for HSPs and partnering agencies.

Investments into new and enhanced services, made by the Central West LHIN in 2013/14, underwent a rigorous review in 2014/15, which included the collection of supplementary data and face-to-face meetings with HSPs who received new funding. During the review HSPs were required to demonstrate whether they had achieved their performance obligations, what value was associated with the investment in question, and what impact it had on the local health care system. Key findings from the review included the need for more detailed planning with HSPs about how to implement new funding in a timely manner, stronger alignment with system partners, removal of policy barriers, and a better understanding of the value of each new investment. Findings and observations from this review have been used to improve processes used by the Central West LHIN to allocate new funds.

SECTION 2 | Healthy Change in Action

While the LHIN's strategic directions are shaped by provincial priorities, ABP 2015/16 reflects local initiatives. It describes how, in collaboration with Health Service Providers (HSPs) and community partners, the Central West LHIN will provide Better Health, Better Care and Better Value for local residents.

Highlighted are specific activities related to Central West LHIN initiatives that align with the four strategic directions identified in IHSP 3 including *Improve Access to Care, Streamline Transitions and Navigation of the System, Drive Quality and Value, and Build on the Momentum*.

Attention is given to the current status of each initiative; activities to be completed during the coming fiscal year; the impact that these initiatives/activities will have on the local health system; and performance measures that will be used to gauge LHIN success. As per MOHLTC guidelines, the status of work (Not yet started, In progress, Deferred or Completed) is indicated as a percentage of completion anticipated over the next three years. "Ongoing" refers to work which, while being completed or complete, will continue to various degrees in subsequent years.

Improve Access to Care

2.1 Improve Access to Primary Health / Family Health Care

IHSP Initiative Description

The Central West LHIN continues to work with Family Health Teams (FHTs), Community Health Centres (CHCs) and other primary care practitioners practicing in other models of organized care to ensure residents have timely access to multi-disciplinary primary care, provided in appropriate settings as close to home as possible. The LHIN is working with providers to develop systems and processes that will reduce avoidable visits to Emergency Departments (EDs).

Current Status

Approximately 560 family physicians provide care throughout the Central West LHIN (*Ontario Physician Health Data Resource Centre, 2013). Residents have access to six FHTs, two CHCs, 33 Family Health Groups (FHGs), 13 Family Health Organizations (FHOs) and over 180 individual fee-for-service practitioners.

Attachment to a primary care physician is high, with 95% of Central West LHIN residents reporting they had a regular family doctor in 2013/14 (*Health Care Experience Survey, June 2014). While most residents report having a family doctor, access to that provider when individuals need service remains a concern: Only 54% of residents reported being able to see their primary care provider on the same or next day when sick.

Residents do not appear to be turning to local EDs for conditions that should be manageable within the community. Despite the Brampton Civic Hospital having the busiest ED in Ontario (131,309 visits in 2013/14, as compared to 106,520 at Thunder Bay Regional Health Sciences Centre, the next busiest ED in Ontario), the three Central West LHIN EDs have lower proportions of low acuity visits compared to the provincial average (Canadian Triage and Acuity Scale IV/V: 28% vs. 40%) and the lowest rate of ED visits among the 14 LHINs for conditions such as conjunctivitis, cystitis, otitis media and upper respiratory infections, that could be treated in primary care settings (1.1 per 1,000 population aged 1-74 years).

The Central West LHIN continues to support the Central West Primary Care Network. This group, led by the Central West Physician Primary Care Lead, continues to support and develop diverse partnerships and strategies to engage local primary care practitioners particularly in initiatives such as Health Links.

Alignment with Government Priorities

Patients First - Ontario's Action Plan for Health Care identifies timely access to primary care and improved transitions among providers as key components to ensuring Ontarians receive the right care, at the right time and in the right place. Through the collaborative work of Health Links, FHTs, CHCs, the Central West Community Care Access Centre (CCAC) and the Central West Primary Care Network, patients will receive faster care, spend less time waiting for service and will be supported by a team of providers across the health care system.

Action Plans/Interventions	2015/16	2016/17	2017/18
Work with Health Links and Health Care Connect to ensure residents who do not have a primary care practitioner are assigned one.	70%	30%	Ongoing
Work with FHTs, CHCs, Health Links the Central West CCAC and Central West Primary Care Network to improve access to multi-disciplinary primary care, advanced access models, and specialty care as close to home as possible.	70%	30%	Ongoing

Expected Impacts of Key Action Items

More residents will have access to after-hours care and same-day or next-day appointments and fewer individuals will require care in hospitals for conditions that are better managed in primary care settings.

Outcome Metrics:

- Increase the proportion of residents who report access to same or next-day appointments to 75%.[1]
- Maintain current performance on avoidable emergency department visits for conjunctivitis, cystitis, otitis media and upper respiratory infections (< 1.5 visits per 1,000 population aged 1-74 years).[2]

[1] CHC, FHT and other primary care supplemental reporting | [2] National Ambulatory Care Reporting System (NACRS): through Canadian Institute for Health Information (CIHI) portal

Risks/Barriers to Successful Intervention	
Risk	Mitigation Strategy
Year-over-year population growth will increase pressure on the availability of and access to local family physicians for residents within the Central West LHIN.	▪ Continue to use and monitor referral patterns to primary care through Health Care Connect. ▪ Monitor physician supply, recruitment and model adoption through the LHIN's Health Force Ontario Community Partnership Coordinator. ▪ Monitor referral patterns to Health Links for barriers to access and growth in demand.
Access to and communication of relevant patient information across Health Service Providers impedes timely access to care.	▪ Continue to adopt and support the use of eHealth infrastructures that improve the availability and transferability of client-based information.
Varying levels of physician support for Central West LHIN initiatives.	▪ The Central West LHIN will continue to work with Ontario Medical Association (OMA) / Ontario College of Family Physicians (OCFP) leadership, the Primary Care Lead and Central West Primary Care Network to support physician championship of programs and services. ▪ The Central West LHIN will implement a managed growth model of physician engagement/relationship development.

Key Enablers

Building on strong partnerships with local FHTs, CHCs, the LHIN's five Health Links and the Central West CCAC the LHIN will continue to support and invest in efforts that forge relationships, information exchange and patient transitions among primary care, acute care and community service partners.

2.2 Improve Access to Chronic Disease Prevention and Management Programs

IHSP Initiative Description

The Central West LHIN is working with community partners to increase capacity for the self-management of chronic conditions in order to improve the treatment and management of chronic diseases in the community. Efforts made to-date to improve the coordination of regional diabetes services will continue. In addition, the LHIN will continue to expand education and self-management programs for chronic diseases including Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).

Current Status

Four HSPs in the Central West LHIN deliver diabetes education programs funded by the MOHLTC. In 2013/14, the active client caseload increased by three percent for residents attending local diabetes education programs. The rate of ED visits for hyperglycemia and hypoglycemia was 164 visits per 100,000 people with diabetes in 2014/15, below the established target rate of ≤198 per 100,000 people with diabetes. The number of readmissions to hospital within 30 days of discharge for conditions related to diabetes has been at or below the evidence-based expected rate of 13%. These indicators reflect the success of local diabetes education and self-management programs.

In 2015/16, the Central West LHIN will continue to explore access to chronic disease education and self-management programs for residents living with CHF and COPD. Heart failure is predominantly a chronic disease within the elderly and the most common cause of hospitalization for individuals over 60 years of age. CHF carries a substantial burden of mortality and

morbidity for residents in the Central West LHIN. The annual mortality rate of CHF within the LHIN is six percent and morbidity associated with heart failure is high. In 2013/14, approximately 21% of residents hospitalized with CHF were readmitted within 30-days of discharge. Similarly, 20% of residents hospitalized with COPD were readmitted within 30-days of discharge.

In early 2013 the Central West LHIN introduced the regional Telehomecare program that supports eligible residents with CHF and COPD to better self-manage their care with the support of remote monitoring technology placed in their home. With the assistance of this technology, patients are monitored by Telehomecare Nurses working from the host organization, William Osler Health System. Patients are referred from a number of regional partners including Headwaters Health Care Centre, the Central West CCAC, CHCs and primary care physicians. Results of the Telehomecare pilot program have demonstrated the ability of patients to better self-manage their conditions within their communities, and to avoid and prevent unnecessary use of acute/ambulatory services. An evaluation of the first Telehomecare cohort of patients, who completed a six month program period, revealed a 40% reduction in ED visits and 49% reduction in inpatient admissions.

Alignment with Government Priorities

The Central West LHIN is committed to improving access to CDPM programs and services by building on the foundations of the Ontario CDPM Framework, leveraging the work of local diabetes programs and expanding roles that promote self-management while delaying and/or preventing the onset of complications of chronic diseases. This work is aligned with *Patients First* - Ontario's Action Plan for Health Care, placing patients at the centre of the health care system by supporting them to self-manage their chronic conditions within the community. Improving access to community support services ensures better value for service outside the hospital setting.

Action Plans/Interventions	2015/16	2016/17	2017/18
In support of Health Links and in partnership with local HSPs, develop the local strategy for management of CHF in alignment with the Cardiac Care Network's provincial Heart Failure Strategy.	100%	Ongoing	Ongoing
Develop and implement three integrated care pathways for the management of diabetes in the Central West LHIN.	In progress 20%	20%	Complete
Diabetes Education Programs evaluate barriers to accessing care for diabetes by completing the Health Equity Impact Assessment (HEIA) tool.	In progress 40%	Ongoing	Ongoing
Increase the capacity of community-based providers to deliver evidence-based, best practice care for residents with COPD. Includes supporting the adoption of the Value Demonstrating Initiative (VDI) on COPD in primary care settings.	60%	40%	Ongoing
Coordinate the transition of hospital Quality Based Procedures (QBPs) into community settings for CHF and COPD patients.	75%	25%	Ongoing
Support awareness of and referrals to the Telehomecare program amongst local HSPs, and expand the program to other chronic diseases such as diabetes.	60%	20%	20%

Expected Impacts of Key Action Items

By the end of 2015/2016, more residents living in the Central West LHIN will receive diabetes care according to evidence-based best practices. Residents living with other chronic diseases including CHF and COPD will receive enhanced support to manage their conditions outside of hospital settings. As a result, fewer individuals will require readmission to hospital following initial disease stabilization.

Outcome Metrics:

- Improve the rate of readmissions within 30-days of discharge for CHF diagnoses to within 10% of the expected rate.[1]
- Improve the rate of readmissions within 30-days of discharge for COPD diagnoses to within 10% of the expected rate.[1]
- Maintain a rate of readmissions within 30-days of discharge for diabetes diagnoses within 10% of the expected rate.[1]

- Reduce the rate of emergency room visits for both hyperglycemia and hypoglycemia by 10% by the end of 2015/16.[2]
- Increase the volume of active adult clients in funded diabetes programs by 5% by the end of 2015/16.[3]
- Increase the proportion of client enrollment into the Telehomecare program by 40% with a yearly target of 700 clients for the fiscal year 2015/16.

[1] Discharge Abstract Database (DAD): through CIHI portal | [2] NACRS: through CIHI portal | [3] LHIN funded Diabetes Education Program supplemental reporting

Risks/Barriers to Successful Intervention	
Risk	Mitigation Strategy
Referral processes to education and self-management programs are not consistent across providers.	▪ Referrals made to the Diabetes Education Programs will be consistent through use of a common referral form.
Varying levels of physician support and engagement for Central West LHIN initiatives relating to chronic disease management.	▪ The Chronic Disease Management team in the Central West LHIN is implementing a focused strategy for physician engagement. ▪ The team will work with the Chronic Disease Prevention and Management Initiative Core Action Group and the Primary Care Network to foster communication and knowledge transfer between stakeholders.
Impact of chronic disease self-management may not be fully realized in short-term use outcomes.	▪ The Central West LHIN will focus on measuring performance in ways that allows gradual improvements to be identified and monitored over time through its balanced scorecard and indicator dashboards.

Key Enablers

The Central West LHIN and William Osler Health System are co-chairing the development of the Central West Healthy Communities Initiative. The initiative involves William Osler Health System, the Region of Peel, Peel Children and Youth Initiative, the Primary Care Lead, local school boards and the Ministry of Community and Social Services. With the development of the Peel Memorial Centre for Integrated Health and Wellness acting as a catalyst for change, there is an opportunity to focus resources in the Central West LHIN to support a collective positive healthy change initiative. The selected area of positive change is a collective effort to reduce the effect of childhood obesity and diabetes throughout the LHIN through the collective and collaborative involvement of these key organizations.

2.3 Improve Access to Mental Health and Addictions Services

IHSP Initiative Description

Aligning with years 4-10 of *Ontario's Comprehensive Mental Health and Addictions Strategy*, the Central West LHIN is working with community partners to increase capacity for community-based programs, and to improve access to Mental Health and Addictions services for adults. These efforts will build on the momentum and success of the first three years of the *Strategy* which had a focus on children and youth.

Current Status

The Central West LHIN funds eight HSPs that deliver over 20,000 mental health and addictions interactions with local residents each year. Services range in function, intensity and duration and include case management, crisis response,

counselling and treatment, early intervention, support within housing, residential withdrawal management, diversion and court support, social rehabilitation, recreation, health promotion and employment support.

Providers are being guided by the following five-year vision for Mental Health and Addictions services: "high quality and seamless services that are easily accessed, efficient, available in a timely way, meeting the changing needs of people over their lifetime". This vision emerged from a time-intensive, short-term project with the LHIN and HSPs, to identify program priorities and investments over the next five years. With a focus on access to care, two key priorities emerged during 2014/15 including helping clients' access and change care as needed, and improving the quality and use of crisis services.

Helping clients access and change care as needed began with the LHIN and HSPs discussing existing service capacity, strengths and challenges within the system, and finally determining priorities for program investments in 2014/15. In all, a significant annualized investment of $3.7M, 25% of the 2014-15 community funding total, was approved to address each of the following service priorities, with the aim to serve an additional 1,150 clients. Highlights of these new investments include:

- Reduce or eliminate the existing combined wait list of over 250 residents by expanding long-term case management and early intervention. Early intervention supports individuals 14-35 years of age experiencing first signs of mental illness.
- Enhance Family Support and expand Social Rehabilitation/Recreation to serve an additional 150 individuals as a systemic way to support clients to access and move to and from more or less resource-intensive services as needed.
- Leverage known housing stock to provide support within housing to eight individuals through a partnership of two providers: the first securing housing and supporting tenancy and the second providing support services.

The second priority was to improve the quality and use of crisis services, a key strategy to provide residents an alternative to repeated use of the Emergency Department (ED) and to better identify when it is necessary to visit the ED. Activities in 2014/15 built on a new program called Short-Term Emergency Department Diversion (In-STED), whereby patients are provided with immediate short-term case management often while still at the ED. The following improvements have been tested and continue to be tested and/or were introduced to practice:

- Redevelop mobile crisis services.
- Standardized discharge plans were tested with 60 patients who had seen the crisis intervention team at the Etobicoke General Hospital site of William Osler Health System – only seven then visited the ED again.
- Acceptable referral sources were widened for short-term residential crisis support and less restrictive criteria was established for who can use the service i.e. not limited to justice-involved individuals.
- Follow up calls were tested and the 48 of 130 residents reached did not have another visit to Headwaters Health Care Centre – the patients were stable and as needed, they were connected to additional services.
- Adoption of person-centred and family-involved crisis planning approach consistent with local child and youth services' practice that defers to clients to decide more practical strategies for self-managing a crisis, increasing the likelihood that the crisis plan will be followed – planned implementation is underway.
- Capability for mental health and addictions staff to provide coordinated care by accessing relevant clinical records (with client consent) at William Osler Health System and the Central West CCAC.
- Through consultation with persons with lived experience (consumers), health and social services, crisis services will be integrated with the centralized access model that is under development.

Alignment with Government Priorities

Improving mental health services throughout the lifespan is one step toward ensuring all Ontarians receive better access, better quality and better value from their healthcare system. The initiatives and outcomes the Central West LHIN is pursuing are aligned to Patients First - *Ontario's Action Plan for Health Care, Ontario's Comprehensive Mental Health and Addictions Strategy* for adults, and *Moving on Mental Health: A system that makes sense for children and youth.* Through early identification and intervention and enhanced community-based services, the LHIN is working to ensure that residents with mental health and addictions receive timely access to the most appropriate services as close to home as possible.

Action Plans/Interventions	2015/16	2016/17	2017/18
Adopt, execute and monitor a coordinated access model for mental health and addiction services.	In Progress 40%	Ongoing	Ongoing
Working with HSPs, municipal service managers and MOHLTC plan the expansion of supportive housing and expand Support Within Housing services to 100 clients.	In Progress 50%	30%	10%
Determine a strategic approach to improving age-appropriateness of services for youth and building capacity of health service providers to shift care/support to more preventative and proactive interventions with clients.	Not Yet Started 80%	20%	Complete
Partner with other funders, system planners, and providers to plan and integrate mental health and addiction services at locations designed as community service hubs.	Not Yet Started 50%	25%	25%
Expand the use of Ontario Telemedicine units for the purpose of implementing the local Narcotics Strategy.	Ongoing	Ongoing	Ongoing

Expected Impacts of Key Action Items

By acting on these initiatives, more residents with mental health and/or addiction issues will have faster access to the mix of services which meet their individual needs closer to home. More children and youth will receive services integrated with their school setting; more clients will have access to collaborative multi-disciplinary care; and the most appropriate residents will receive care in ambulatory and inpatient settings.

Outcome Metrics:

- Reduce the number of repeat, unplanned emergency visits within 30 days for mental health conditions to MLPA target.[1]
- Reduce the number of repeat, unplanned emergency visits within 30 days for substance abuse to MLPA target.[1]
- Reduce the rate of unplanned emergency visits for mental health and substance abuse conditions among youth aged 15-24 years by 10% by the end of 2015/2016.[1]

[1] NACRS: through CIHI portal

Risks/Barriers to Successful Intervention

Risk	Mitigation Strategy
Existing structures and jurisdictional boundaries may hinder the change management required to meet the needs of the youth and young adult population.	▪ The Central West LHIN will facilitate and monitor discussions amongst providers of children and adult services to share expertise and align structures, priorities and funding that support system transformation.
HSP capacity to respond on a timely basis along with individual's readiness/willingness for treatment can preclude the Central West LHIN's ability to reduce ambulatory visits for substance conditions.	▪ HSPs in the Central West LHIN understand the nature of addictions and help-seeking behavior. ▪ Discussions will continue amongst providers around creating and sustaining models of service which are more responsive to residents at all stages and locations where help is sought.
Program implications and associated costs with implementing coordinated access models for mental health and addictions across the Central West LHIN's geography may be prohibitive to justify executing preferred care models.	▪ The Central West LHIN will continue to monitor and learn from the costs and considerations incurred in other LHINs undergoing similar processes. ▪ The choice of access models put forward to the Board will be feasible and scalable.

Key Enablers

The Central West LHIN is committed to increasing the capacity of community-based services for mental health and addictions and to sustaining this commitment to both hospital and community mental health and addiction service providers and relevant child and youth serving agencies. Electronic enablers, including consolidated client record management and business management systems, are required in addition to ongoing collaboration with HSPs. The Central West LHIN will continue to align funding with the province's *Comprehensive Mental Health and Addictions Strategy* and to work with regional staff across Ministries and municipalities to implement system transformation that improves mental health and well-being for the residents within the Central West LHIN.

2.4 Improve Access to Community-Based Services for Seniors

IHSP Initiative Description

The Central West LHIN is working with funded community service providers to develop strategies to support seniors in the community and increase quality of life. This work is aligned with the province's health initiatives for seniors and aims to reduce avoidable ED visits, hospital admissions and Alternative Level of Care (ALC) designations.

Current Status

The Central West LHIN funds community-based organizations that deliver services to support the independent living of seniors. The range of services provided include delivery, social/safety visiting, congregate dining, adult day programs, transportation, exercise/falls prevention, chronic disease management, caregiver support, independence training, psychogeriatrics and responsive behaviour support, assisted living, respite and palliative care. The LHIN also provides funding to the Central West CCAC to deliver nursing, rehabilitation and personal support services, rapid response nursing, palliative care, community clinics and supportive living. The Central West CCAC coordinates access to 23 Long-Term Care (LTC) homes across the LHIN.

- In 2013/14 seniors comprised 11% of the population of the Central West LHIN and this percentage is expected to grow to 12.7% by 2017 and 14.7% by 2022. The fastest growing age group in the Central West LHIN is 65 to 74 years of age with a projected increase of 19% by 2017.
- Seniors account for 50% of the complex high needs patients in the Central West LHIN.
- There were 18,506 hospital admissions of seniors from the Central West LHIN in 2013/14. Seniors accounted for 83% of all Alternate Level of Care (ALC) cases and 85% of ALC days.
- Senior residents of the Central West LHIN made 46,035 emergency department visits in 2013/14, 78% of those were to hospitals within Central West LHIN. Seniors accounted for 17% of all emergency department visits made by residents of the Central West LHIN.
- In 2013/14, the MOHLTC implemented a broader access to Physiotherapy Services through clinic service expansion, in-home physiotherapy access through CCACs and services within LTC homes. LHINs led a local approach to expand exercise and falls prevention classes for seniors. The Central West LHIN invested approximately $500,000 to expand exercise and falls prevention classes through a unique model led by the Central West CCAC. The goal was to implement a total of 149 classes in approximately 50 locations within the Central West LHIN. The Central West LHIN and the Central West CCAC developed a partnership with the City of Brampton to increase accessibility of these programs for seniors by implementing a number of classes across community facilities in Brampton.
- In 2013/14 Central West LHIN funded an additional Adult Day Program operated by The Alzheimer Society of Peel in Brampton. This brought the total number of Adult Day Programs to nine with capacity for 238 seniors. An Aphasia Program was added to the Tall Pines Adult Day Program to provide a new service for seniors who have suffered a stroke. Community funding in 2014/15 was used to extend the hours of the Peel Manor Adult Day Program to accommodate an additional 10 seniors per day. The Central West CCAC coordinates access to all adult day programs.

- In 2014/15, the Central West LHIN invested $1.6 million in new base funding to expand adult day service hours, respite programs, caregiver support programs and Tele-check programs in Dufferin County. Bethell Hospice received funding to hire Psychosocial Spiritual Care Coordinators to work as part of the Shared Care Team in Palliative Care.
- Over the past two years the Central West LHIN added 205 assisted living spaces in Shelburne, Orangeville, Brampton, Etobicoke and Woodbridge, bringing the total number of funded places to 629. The Central West CCAC manages the access to all assisted living beds and chairs a multi-agency committee to monitor and continuously improve the use of the assisted living inventory.
- In 2014/15 the MOHLTC made multi-year Assess and Restore money available and Central West LHIN worked with the Central West CCAC to reinstate the Home Independence Program (HIP) which provides targeted rehabilitation services to frail elderly in their homes.
- In March 2014, Phase 1 of the new Kipling Acres LTC Home officially opened. Kipling Acres in Etobicoke is the largest LTC Home in the Central West LHIN and was built in 1959. Kipling Acres and Pine View Lodge were the first two homes in the Central West LHIN to upgrade their facilities under the MOHLTC Redevelopment Plan. Over the coming years, 8 additional LTC Homes, representing over 1000 beds, will be eligible for redevelopment.
- In 2014/15, guided by recommendations of Dr. Sinha's *"Living Longer, Living Well"* report, the Central West LHIN commissioned the completion of a Community Capacity Study of services for seniors to identify any current service gaps and potential future challenges within in the system.
- In 2014, an evaluation was conducted on the Central West Behaviour Supports Ontario (BSO) program. This evaluation showed that the 23 behavior support champions embedded in each of the long-term care (LTC) homes, along with the 7 psychogeriatric resource consultants, were able to reduce the number of responsive behaviours by 47%.

74% of senior residents who were hospitalized last year were discharged to home-based settings, a reflection of the LHIN's investments in Central West CCAC and community-based services. However, there is room for improvement. Seniors continue to account for high use of hospital services in the LHIN, comprising 17% of ED visits, 31% of hospital admissions and 85% of ALC days. Residents also wait too long in EDs; 1 in 10 seniors are waiting 39 hours or more from the time they present in the ED until admission to an inpatient bed. Findings of the governments Home and Community Care Working Group are expected in January 2015 and these will be incorporated into the seniors work plan.

Alignment with Government Priorities

The Central West LHIN's initiative to improve access to and funding for community-based services for seniors is aligned with *Patients First* - Ontario's Action Plan for Health Care, which encourages the development of local seniors strategies which focus on supporting seniors to stay healthy and stay at home longer. The Central West LHIN's Seniors Strategy will incorporate the five principles of *Access, Equity, Choice, Value and Quality* outlined in Dr. Sinha's *"Living Longer, Living Well"* report, and the Ministers' Mandate Letters. Development of a comprehensive system of seniors care will also incorporate the MOHLTC newly released Assess and Restore Guideline and the work of the provincial Rehabilitative Care Alliance.

Action Plans/Interventions	2015/16	2016/17	2017/18
Finalize the Central West LHIN Seniors Strategy, incorporating the findings from the Community Capacity Study, the provincial recommendations made in *Living Longer, Living Well* and the Ministers' Mandate Letters to develop annual work plans for the development of integrated home and community care for seniors and to inform funding allocations.	In Progress 100%	Complete	Complete
Fully implement the Assess and Restore initiatives to support the transitions of frail seniors between hospital and home.	In Progress 100%	Complete	Complete
In accordance with the new government policy framework, develop a multi-year schedule for the redevelopment of Long-Term Care home beds in the Central West LHIN.	100%	Ongoing	Ongoing

Action Plans/Interventions - continued	2015/16	2016/17	2017/18
Improve the care of seniors suffering from dementia through the Behaviour Supports Ontario (BSO) program, establishment of memory clinics and the integration of psychogeriatrics into seniors programs.	On going	On going	On going
Partner with other funders, system planners, and providers to plan and integrate services for seniors at locations designed as community service hubs.	On going	On going	On going
Based on the recommendations of the Expert Panel on Home and Community Care, work with local providers to develop, implement and evaluate an integrated acute and post-acute home care model for selected conditions.	50%	50%	Ongoing

Expected Impacts of Key Action Items

The Central West LHIN will improve the care delivered to seniors by following a strategy-based action plan that will identify and fill service gaps and enhance service providers' abilities to deliver comprehensive, integrated best practice care.

Outcome Metrics:

- Reduce the number and proportion of hospital days stayed on an ALC among seniors discharged from acute inpatient, rehabilitation and Complex Continuing Care beds from current levels.[1]
- Increase the proportion of seniors discharged to home settings from local EDs and inpatient beds from current levels. [2]
- Meet MLPA target for 90th percentile wait time for CCAC in-home services from the community setting.[3]
- Establish a baseline and set targets for the proportion of low and moderate needs clients referred by CCAC to Community Support Services.[3]

[1] Wait Time Information System (WTIS). Access to Care (ATC) iPort through Cancer Care Ontario (CCO) | [2] NACRS through CIHI portal | [3] CCAC supplemental reporting to the LHIN

Risks/Barriers to Successful Intervention

Risk	Mitigation Strategy
High rate of growth occurring among the seniors population in the Central West LHIN puts increasing pressure on the demand for, access to, and supply of local health services.	▪ Continue to monitor senior's population growth and use impact. ▪ Develop a comprehensive local Seniors Strategy
Limited supply of specific health care professionals and their interest in practicing in community-based settings (e.g. nurse practitioners) may affect the ability of health service providers to staff funded programs (e.g. Nurse Led Outreach Team (NLOT), Palliative Care).	▪ Support local partners in recruitment efforts.
Lack of high quality, timely data on service use specific to seniors.	▪ The LHIN will focus on measuring performance using sources and indicators that captures improvements specific to the seniors population. These indicators will be monitored and tracked through use of the Senior's Performance Dashboard.
Recognizing the cultural diversity of resident demographics in the Central West LHIN, culturally-appropriate approaches to service delivery must be considered if seniors are to live successfully in home-based settings.	▪ The Health Equity Impact Assessment Tool will be used to evaluate barriers to accessing care for seniors. ▪ Feedback from community engagement sessions, Health Equity Plans and input from Health Service Providers, with expertise in serving diverse seniors communities, will be used to monitor and promote cultural awareness. ▪ Continued funding of ethno-cultural seniors programming.

Redevelopment of LTC beds could result in the loss of 100+ beds to the system for a period of years as successive homes are redeveloped.	▪ Robust home and community programming will be needed to support seniors and temper demand for Long-Term Care Homes.

Key Enablers

Building on strong partnerships with the Central West CCAC, LTC homes, the five Health Links partners, local hospitals and community-based HSPs, the Central West LHIN will continue to support and invest in efforts that improve access to community-based services for seniors. Fundamental to supporting system performance and keeping senior residents out of institutional and acute care settings, is the active participation of the Services for Seniors Core Action Group and use of use data that is specific to seniors.

Streamline Transitions and Navigation of the System

2.5 Improve Linkages With and Among Primary Health/Family Health Care and other Providers in the Health Care System

IHSP Initiative Description

Through the Health Links initiative, the Central West LHIN will support the increased coordination of Central West CCAC care in primary care settings to ensure the provision of collaborative and coordinated community-based care. The LHIN is focusing on populations with complex high needs, who access care from multiple providers or are disadvantaged, marginalized and struggle to get the care they need, when and where they need it.

Current Status

In 2013/14 the Central West LHIN led the development of five Health Links including Bolton–Caledon, Bramalea and Area, Brampton and Area, Dufferin Area and North Etobicoke-Malton-West Woodbridge. It was one of the first of Ontario's 14 LHINs to fully implement Health Links across its entire geographic area. Each local Health Link is implementing a common business plan and creating a standard model of care to ensure a consistent experience for patients and providers.

The ongoing identification of Health Links patient population is based on the adoption of a common definition of complex high needs patients with 4+ co-morbidities across the Central West LHIN. Health Links will increase the capacity of primary care providers to seamlessly care for these complex high needs patients and encourage greater collaboration between local providers in order to improve outcomes. As of November 2014, the number of complex high needs patients of the health care system in the Central West LHIN is projected to be approximately 42,000 or five percent of the Central West LHIN total population. Health Links care coordinators are developing individualized coordinated care plans for each identified complex high needs patient.

In 2015/16, the focus of Health Links will be to continue to identify complex high needs patients within the community and to develop coordinated care plans that capitalize on available local resources and information from across the complete continuum of care. Health Links will continue to extend their reach through increased community and provider awareness and engagement around the common goal of providing better and coordinated care to complex high needs patients. In support of Health Links, the Central West LHIN invested in additional Care Coordinators. Managed through the Central West CCAC, their specific focus is to develop and implement coordinated care plans for the most complex high needs residents in the Central West LHIN.

The Central West CCAC continues to explore and enhance strategies aimed at increasing alignment and coordination between primary care settings. These strategies will improve care for all clients with a focus on collaborative care planning for complex clients who use significant resources from multiple health service providers.

Also in 2013, the Central West LHIN became one of three LHINs to pilot the provincial Telehomecare project. The aim of the Telehomecare program is to electronically link patients with complex chronic conditions with a nurse, who can then remotely monitor and rapidly respond to changes in health information. To date, the Telehomecare program has received 2,040 new referrals, 1091 clients have been enrolled and 806 clients have been discharged. In 2015/16, the Telehomecare program will continue to align with Health Links be a supportive self-management tool for complex high needs patients.

Alignment with Government Priorities

Two goals of *Patients First* - Ontario's Action Plan for Health Care are to have a family health care provider for every Ontarian who wants one, and to provide more patients with faster and more convenient access to this care. Health Links will encourage greater collaboration among existing local health care providers. With improved coordination and information sharing, identified residents will receive faster care, will spend less time waiting for services and will be supported by a team of health care providers at all levels of the health care system.

Action Plans/Interventions	2015/16	2016/17	2017/18
Continue to identify complex high needs patients within the LHIN on an ongoing basis and ensure that at least 10,000 high needs patients have a documented care plan which encompasses Health Link partners across the continuum of care.	In Progress 60%	40%	Ongoing
Continue to align existing local, regional, LHIN and Health Link resources to streamline care planning processes and decrease duplication of efforts.	In Progress 60%	40%	Ongoing
Reduce the wait time from primary care referral to specialist consultation for complex patients.	Not Yet Started 80%	20%	Ongoing
Work with local providers to develop integrated care pathways and care plans using the electronic Coordinated Care Tool to assist complex high needs patients in navigating the local health system after discharge from hospital.	40%	30%	30%

Expected Impacts of Key Action Items

By the end of 2015/2016, 10,000 complex high needs patients within the Central West LHIN are expected to have active coordinated care plans. More residents will have access to after-hours care and same-day or next-day appointments and fewer individuals will require care in hospitals for conditions that are better managed in primary care settings.

Outcome Metrics:

- 10,000 complex high needs patients identified through Health Links will have coordinated care plans.[1]
- Establish baseline and targets for 50th percentile and 90th percentile wait time from time of referral to first consultation with a specialist (by specialty).[2]
- Establish baseline and set targets to reduce the rate of 30-day all-cause readmissions to hospital for enrolled Health Link patients.[1,3]
- Establish base-line and set targets to reduce the rate of emergency department and inpatient visits for enrolled Health Link patients.[1,3]
- Reduce the number of 30-day all-cause readmission to hospital for high users in the Central West LHIN.[3]

[1] Health Link quarterly report | [2] WTIS reports through ATC iPort | [3] DAD: through CIHI portal

Risks/Barriers to Successful Intervention	
Risk	Mitigation Strategy
Projected population growth of Central West LHIN will increase demand on the supply of, and access to, primary care practitioners.	▪ Continue to use and monitor referral patterns to primary care through Health Care Connect. ▪ Monitor physician supply, recruitment and, model adoption through the LHINs Health Force Ontario Community Partnership Coordinator. ▪ Monitor referral patterns to Health Links for barriers to access and for growth in demand.
Lack of availability of a provincial electronic Care Coordination Tool impedes the ability to link providers to care plan.	▪ Continue to coordinate care planning via hard copies and look for opportunities to use current technology such as the Central West CCAC's CHRIS system and primary care electronic medical records
Access to and communication of relevant patient information across HSPs impedes timely access to care.	▪ The Central West LHIN will continue to adopt and support the use of eHealth infrastructures that improve the availability and transferability of client-based information.

Key Enablers

Building on strong partnerships with local FHTs, CHCs, five Health Link partners and the Central West CCAC, the Central West LHIN will continue to support and invest in efforts that forge relationships, improve information exchange and patient transitions between primary care, acute care and community service partners.

2.6 Improve System Navigation Resources

IHSP Initiative Description

The Central West LHIN is working with community and hospital-based service providers to understand and address barriers to system access. The LHIN is also working with providers to develop integrated care pathways and care plans to help understand where and when health care access is needed after discharge from hospital. The LHIN continues to partner with community and government agencies to strengthen system navigation and support the establishment and use of services, such as Health Links and Telehomecare.

Current Status

In 2013, the Central West LHIN Patient Flow Core Action Group was formed with the mandate to identify strategies and recommend actions surrounding capacity planning, knowledge translation and issues of transition/navigation management. Strides are being made to improve hand-offs between hospital care and community agencies through continued application of the "Home First" philosophy, implementation of Aging at Home initiatives and community investments, and the introduction of Telehomecare and Health Links.

The establishment of five local Health Links will improve care for all residents with complex conditions through the use of individualized care plans that detail how coordinated support from an integrated team of Health Service Providers will be provided.

Several barriers to access have been and continue to be addressed within the Central West LHIN. The Central West CCAC assumed management of eight adult day programs and six assisted living programs operating in 18 locations across the Central West LHIN. Three agencies received community funding to increase transportation services. Outpatient rehabilitation services remain limited for LHIN residents and the number of patients discharged home following hip and knee replacement surgery has increased by 10%. The LHIN continues to explore best practice pathways for rehabilitation care to support recovery within the community.

In 2014, a sub-set of the Patient Flow Core Action Group, the Transitions Working Group, developed a report which included eight recommendations to be launched to improve transitions across the LHIN.

Alignment with Government Priorities

The Central West LHIN is committed to ensuring residents receive improved access to care in the most appropriate settings. LHIN priorities are reflected in the Central West CCAC's expanded role of waitlist management, the ongoing support for Home First, and the implementation of Health Links. The Action Plans are focused on integrating local health care while reducing and eliminating barriers to service.

Action Plans/Interventions	2015/16	2016/17	2017/18
Develop and implement post-acute/post-discharge care plans for Adult Day Programs, Assisted Living and Respite services and incorporate with Health Link Care Plans where appropriate.	In Progress 50%	Ongoing	Ongoing
Drive the local implementation of integrated best practice rehabilitation care pathways and care plans for patients discharged from hospitals	Not Yet Started 50%	50%	Ongoing
Evaluate the recommendations from the Community Capacity Study regarding Transportation services.	100%	Ongoing	Ongoing
Develop and implement Health Link Care Coordination plans for Telehomecare clients.	80%	20%	Ongoing
Work with LTC homes to promote Medical Director privileging at local hospitals, increase in weekend and evening admissions, and remote access to specialty clinical services.	In progress 80%	20%	Ongoing
Expand "warm handoffs" transitions model to facilitate discharge of difficult-to-place patients.	In progress 80%	20%	Ongoing

Expected Impacts of Key Action Items

All prospective clients for assisted living and adult day programs will be assessed and placed by the CCAC through implementation of a centralized wait list. Recipients of adult day programming, assisted living services and respite will have care plans that help them navigate the care and supports they need after discharge.

Outcome Metrics:

- Meet MLPA target for 90th Percentile wait time for CCAC in-home services from the community.[1]
- Meet MLPA target for rate of readmissions within 30-days of discharge for select case-mix groups.[2]
- Increase the number of clients enrolled in the Telehomecare program from 500 per year to 700 per year for a total of 1800 clients enrolled by the end of 2015/16.[3]
- Increase the number of patients discharged home following hip and knee replacement to 90%.[2]
- Decrease the number of patients designated ALC-LTC with a barrier to discharge of "behavioural issues."[4]

[1] CCAC supplemental reporting to the LHIN | [2] DAD through CIHI portal | [3] Telehomecare supplemental reports from WOHS to the LHIN | [4] WTIS reports through ATC iPort

Risks/Barriers to Successful Intervention

Risk	Mitigation Strategy
Barriers to access may require pan-LHIN discussion and/or provincial support. Barriers affecting multiple ministries may be identified that cannot be resolved without collaboration.	▪ The Central West LHIN will work with local Health Service Providers, neighbouring LHINs, and the Ministry of Health and Long-Term Care to identify any barriers and explore opportunities.

Lack of availability of a provincial electronic Care Coordination Tool impedes the ability to link providers to care plan.	▪ Continue to coordinate care planning via hard copies and look for opportunities to use current technology such as the Central West CCAC's CHRIS system and primary care electronic medical records
Lack of data and capability to link episodes of care and monitors residents' transitions within and across the health care system.	▪ The Central West LHIN will focus on monitoring and tracking readily-available performance indicators that reliably capture resident transitions. The LHIN's Decision Support Unit will continue to work with its counterparts at the local and provincial level to establish, link and use appropriate data sets.

Key Enablers

Dr.Sinha's *"Living Longer, Living Well"* report calls for the development, linkage and implementation of innovative care models within and beyond the acute care setting if Ontarians are to remain independent and age in place. These innovative care models require clear identification of processes, timelines, objectives, and accountabilities; buy-in and support from all HSPs and LHIN staff; allocation of time and resources for staff engagement, training, and standardization; and access to timely information to improve communication and collaboration.

2.7 Increase System Collaboration through the use of Information Technologies

IHSP Initiative Description

The Central West LHIN will continue to lead and participate in provincial, regional and local initiatives that support the development of an Electronic Health Record (EHR) for all Ontarians. The EHR is designed to contain and share information from all providers involved in a patient's care. Integral to the EHR is the establishment of Electronic Medical Records (EMR) within Primary Care Physicians' and Specialists' offices across the LHIN. In addition, implementation of other enabling technologies initiatives such as the Integrated Assessment Record (IAR), Hospital Report Manager (HRM), and ConnectingGTA (cGTA) will continue to enable the development of a more complete EHR.

Current Status

In 2014/15, the Central West LHIN continued to make significant strides in planning and implementing enabling technology solutions. Implementation of the Community Care Information Management's (CCIM) common assessment tools, screener tools and IAR have been completed for all in scope HSPs. Use of these tools allows personal health information to be transferred securely between service providers, reducing the workload of agencies and effort of clients. Increasing adoption of the IAR along with the ongoing creation and refinement of LHIN level IAR reports allow the LHIN to better understand select client populations, and begin to monitor strengths and gaps in system services.

Headwaters Health Care Centre continues to expand electronic access of their hospital reports to primary care physicians and specialists through the use of the HRM product. William Osler Health System has also implemented HRM and is sharing their reports electronically with primary care physicians and specialists.

William Osler Health System, Headwaters Health Care Centre, the Central West CCAC and all LTC Homes have implemented Provincial Referral Standards (PRSs) for hospital (acute inpatient) to Central West CCAC referrals, hospital (acute inpatient) to rehab referrals, hospital (acute inpatient) to complex continuing care referrals and hospital (acute inpatient) to LTC Home referrals, under the direction of the Provincial Alternative Level of Care Resource Matching & Referral Business Transformation Initiative (RM&R BTI).

The need for a central intake process has been identified by multiple providers and client populations within the Central West LHIN. Work will continue to identify and implement solutions that match the requirements of central intake across the LHIN for multiple care pathways e.g. Mental Health and Additions, Diabetes and Palliative.

Adoption of physician EMR systems continues to increase in the Central West LHIN and the LHIN continues to have the highest adoption rate in the province, of EMRs by Primary Care Physicians and Specialists. Focus for 2015/16 will shift from Primary Care Physicians to Specialists.

The Ontario Lab Information System (OLIS) has collected more than 80% of provincial lab test results through connections with hospitals, community labs and public health labs. William Osler Health System and Headwaters Health Care Centre are populating OLIS with test results from their labs. Approximately 300 clinicians in the Central West LHIN can now view OLIS data for their patients through their EMR systems. Additionally, approximately 350 clinicians are completing the activities required to view their patient lab data in OLIS and will be connected throughout the year.

The cGTA project continues to work with health care providers to provide a single point of access to patient health information. William Osler Health System is live, feeding data to cGTA and viewing patient data contained in the cGTA clinical document repository. Headwaters Health Care Centre is targeted to go live, feeding and viewing patient data in cGTA, this year. It is expected that 10 community Health Service Providers across sectors in the Central West LHIN will be able to view their patient data in the cGTA repository this year.

The Central West LHIN will closely monitor the Provincial pilot eNotification and eConsult projects with a plan to implement the solutions as soon as they are broadly available.

Alignment with Government Priorities

A key component of *Patients First* - Ontario's Action Plan for Health Care is to achieve greater exchange of electronic information across Ontario's health system. The MOHLTC has specified their priorities to include *Putting Patients at the Centre, Moving Forward on Accountability and Transparency and, Collaborating on Shared Responsibilities across Government*. The action plans identified below are enablers of these priorities and support system collaboration through the use of information technologies.

The MOHLTC, in partnership with eHealth Ontario, has set an ambitious strategy to implement an EHR by 2015. Participation in cGTA, OLIS, HRM, physician EMR adoption and the Care Coordination Tool are necessary requirements to support implementation of the EHR. Innovative electronic health system solutions must be adopted to support integration of information in and across community service agencies. Such systems include the Integrated Assessment Records and Care Coordination Tools, slated to be adopted by the five local Health Links.

Action Plans/Interventions	2015/16	2016/17	2017/18
Expand implementation of Hospital Report Manager.	In Progress 30%	Complete	Complete
Increase local adoption of Specialist Electronic Medical Records (EMRs).	In Progress 15%	10%	Complete
Increase Adoption/Usage of the Integrated Assessment Record (IAR).	In Progress 60%	20%	Complete
Implement the Connecting GTA – Provider Portal and Health Information Access Layer (HIAL).	In Progress 30%	20%	Complete
Implement Recommendations from Community IM/IT Environmental Scan.	Not Started 35%	35%	30%

Develop and Implement a Central Intake Solution.	In Progress 40%	40%	10%
Implement eNotifications.	Not Started 80%	20%	Complete
Implement the Provincial eConsult Solution.	Not Started 10%	90%	Complete

Expected Impacts of Key Action Items

By the end of 2015/2016, primary care practitioners working in the Central West LHIN will have more timely access to their patient's clinical reports, lab results and discharge summaries. This will enable quicker identification of diagnoses, treatments and service gaps. All health service providers will see improved electronic sharing of and, access to patient information.

Outcome Metrics:

- Increase the number of hospital reports transmitted electronically from hospitals to physician EMRs and the CCAC CHRIS system.
- Increase the number of hospitals and physicians using the HRM platform.[1]
- Increase the percentage of specialists who have implemented an EMR.[1]
- Increase the number of local users actively searching and using the IAR.[2]
- Increase the number of patient reports and notifications sent electronically across HSPs.[3]
- Reduce the time it takes for physicians and patients to connect with a care coordinator and receive requested community services.
- Improved wait times for referrals to specialist care.
- Identify opportunities to improve the security of data sharing practices across HSPs.
- Identify opportunities to reduce the IM/IT costs experienced by community service providers.

1 OntarioMD status reports | 2 CCIM status reports | 3 cGTA status reports

Risks/Barriers to Successful Intervention

Risk	Mitigation Strategy
HSPs have limited physical, capital and human resource capacity to implement, sustain and monitor IM/IT solutions.	▪ The LHIN will facilitate ongoing dialogue with Health Service Providers to understanding their priorities and capabilities and align activities where possible. ▪ Identify a champion health lead for each IM/IT project. ▪ The LHIN will continue to build stakeholder awareness, engagement and buy in for IM/IT solutions as early as possible. ▪ Ensure that a sustainability model is created and communicated to the HSPs and to the LHIN in advance of committing to project implementation.
Uncertainty regarding government priorities for IM/IT may impact engagement and participation of health care system stakeholders and champions.	▪ Commitment to government priorities will be reinforced through stakeholder engagement and communications. The LHIN will ensure timely communication of all priority information.

Key Enablers

Information technologies and information management are key enablers to achieving the Central West LHIN's four strategic directions outlined in the IHSP3. To implement these projects successfully, the timely release of funds by both the MOHLTC and the LHIN is imperative. Accountabilities and responsibilities must be clear among stakeholders and change management practices/tools should be in place to support effective adoption. Ongoing partnerships with neighbouring LHINs, delivery partners and health service providers will enhance the ability to leverage regional solutions and sustainability models must be created and communicated to the health service providers and the LHIN in advance of committing to project implementation.

Drive Quality and Value

2.8 Ensure an Overarching LHIN Quality Framework

IHSP Initiative Description

The Central West LHIN supports initiatives aimed at improving quality and safety based on leading practices, while building capability and capacity for improvement. The LHIN will incorporate patient/client experience in quality indicators, and develop a collaborative and integrated approach with HSPs to support the development of quality improvement plans and to undertake accreditation processes.

Current Status

The Board of Directors of the Central West LHIN has maintained a focus on quality during 2014-15. The Quality Committee of the Board provided oversight for the development of three local health system quality aims for improvement. A Governance to Governance and Senior Leader (G2G) Forum on Quality was held to share the provincial perspective on quality from Health Quality Ontario and to reinforce the importance of advancing quality through a collaborative local system level approach. The forum also provided an opportunity to receive feedback on the system level aims with Central West HSP governance and seniors leaders. Work will be completed to map current HSP activities that support the achievement of the system level aims and to identify gaps and opportunities for cross-sector improvement initiatives. Monitoring progress towards the achievement of these aims will occur through the monitoring of a quality dashboard as part of the LHIN's Balanced Scorecard. The LHIN's role in performance monitoring through the Balanced Scorecard and associated quality dashboard provides an overview of the status of the local health care system relative to important indicators of quality, aligned with the strategic directions in the IHSP 3.

The Quality Committee also provides guidance for implementation of the Central West LHIN Quality Framework. The framework provides a foundation for the development and implementation of targeted cross-sector initiatives aligned to the system level aims and designed to build capacity for improvement of quality and safety.

In 2015/16 the LHIN will focus on understanding and improving residents' experience with the local health care system through participation in a Pan-LHIN Patient Experience Survey. This survey will be administered bi-annually to a random sample of residents in the Central West LHIN and the results will be shared with the Quality Committee. Additionally, all HSPs are expected to complete client satisfaction surveys as part of either their legislative requirements or their accountability agreements with the LHIN. The five Health Links in the Central West LHIN will incorporate measurement of patient experience before and after enrollment and the results will be included as part of the quality dashboard.

The two hospitals, two CHCs, and the Central West CCAC completed and submitted Quality Improvement Plans (QIPs) to Health Quality Ontario (HQO) by April 1, 2014. In 2015/16, the MOHLTC has expanded expectations to include LTC Homes, which will be required submit QIPs to HQO by April 1, 2015. As part of their accountability agreements, all community-based HSPs will continue to be required to complete and submit a QIP to the LHIN on an annual basis. The Central West LHIN will continue to request submission of QIPs from HSPs for review and discussion. Opportunities for greater collaboration and

integration of objectives and activities associated with QIPs will be explored in 2015/16 including their link to the implementation of QBPs as part of Health System Funding Reform (HSFR).

In addition to QIPs, accreditation is an important process for all LHIN-funded agencies to undertake to identify areas of excellence and where gaps exist relative to quality standards of care. To date, 9 of 25 HSPs funded by the LHIN to provide community-based services had achieved accreditation. In addition, the two hospital corporations within the LHIN, the Central West CCAC and 21 of 23 local LTC Homes are accredited. Almost all community-based providers have submitted their plans for undertaking accreditation to the LHIN at the end of March 2014. The LHIN is in the process of considering the resources and supports required for the successful completion of the accreditation process, with the expectation that all providers will be accredited by March 31, 2017.

All HSPs in the LHIN have signed Service Accountability Agreements that detail specific performance expectations to be achieved over the term of the agreements.

Alignment with Government Priorities

The LHIN is committed to providing leadership for quality in support of the *Excellent Care for All Act* (ECFAA), Patients First - Ontario's Action Plan for Health Care and the objectives of Ministers' Mandate Letters related to driving a sustainable, accountable and quality health care system. The LHIN's Quality Framework supports the principles of ECFAA and its development has been guided by the attributes of a high-performing healthcare system, defined by HQO. These attributes reflect a system that is accessible, effective, safe, patient-centred, efficient, integrated, equitable, population-health focused and appropriately resourced. Patients First - Ontario's Action Plan for Health Care builds on the ECFAA by setting clear directions for patient's to receive the right care, at the right time and in the right place.

Action Plans/Interventions	2015/16	2016/17	2017/18
Implement quality dashboard for use by the Central West LHIN Quality Committee to monitor and report on local system level aims.	In progress 75%	Ongoing	Ongoing
Support achievement of three identified system level aims for improvement through alignment of existing HSP initiatives and planning of new quality improvement initiatives/projects.	In Progress 50%	Ongoing	Ongoing
Promote and integrate provincial and regional quality improvement processes, tools and resources (i.e.,IDEAS, BestPATH) to support learning, application and exchange among Central West HSPs.	In Progress 50%	Ongoing	Ongoing
Action Plans/Interventions	**2015/16**	**2016/17**	**2017/18**
Investigate and facilitate Central West HSP involvement in the joint Council of Academic Hospitals (CAHO) and HQO initiative Adopting Research to Improve Care (ARTIC) Program to increase adoption of research evidence into practice.	Not started yet 40%	60%	Ongoing
Support completion of Quality Improvement Plans (QIPs) as part of accountability agreements and existing or anticipated MOHLTC requirements related to ECFAA for all Central West HSPs with particular attention to community-based HSPs.	In Progress 50%	Ongoing	Ongoing
Support completion of accreditation processes for all non-accredited community-based HSPs as part of their accountability agreements.	In Progress 40 %	20%	Ongoing
Implement bi-annual patient experience survey as part of Pan-LHIN initiative to measure local health system level indicators of experience and use results to identify areas for improvement for Central West HSPs	In progress 100%	Ongoing	Ongoing

Based on the 2014-15 provider consultation on procurement, support community sector providers to prioritize and improve back office administrative and support services, optimizing shared services available in the Central West LHIN	50%	50%	Complete
Refresh Service Accountability Agreements with Community HSPs; and renegotiate Agreements with Hospitals and Long-Term Care homes.	100%	Complete	Complete

Expected Impacts of Key Action Items

By March 31, 2017, all Health Service Providers within the Central West LHIN will have achieved accreditation and will be completing annual organizational Quality Improvement Plans. Greater alignment of the quality work of HSPs with the Central West LHIN's Quality Framework and system-level aims and continued implementation of quality based procedures (QBPs) will result in more residents receiving safer, accessible, evidence-based, integrated, patient-centred care. These outcomes will be monitored through the following indicators:

Outcome Metrics:

- Monitor LHIN rates of *:
  1) Hospital Standardized Mortality Ratio (HSMR)[1]
  2) In-hospital fractures[2]
  3) Hospitalizations for falls among long-term care residents[3]
  4) Restraint use in long-term care homes[3]
  5) Clostridium difficile Infection (CDI)[4]
  6) Methicillin Resistant *Staphylococcus aureus* (MSRA) Bacteremia[4]
  7) Vancomycin Resistant *Enterococcus* (VRE) Bacteremia[4]
  8) Central Line-Associated Primary Bloodstream Infection (CLI)[4]
  9) Ventilator-Associated Pneumonia (VAP)[4]

[1] Self-Reporting Initiative (SRI) | [2] DAD: through CIHI portal | [3] Continuing Care Reporting System (CCRS) | [4] Critical Care Information System (CCIS)

** Performance below established and LHIN/H-SAA targets defined in the 3-year Balanced Scorecard will trigger follow-up and intervention.*

- Monitor the LHIN's Quality Dashboard on a quarterly basis for progress towards achievement of system level aims
- Monitor patient experience indicators across Health Links to measure performance related to integration and patient-centredness
- Reduce the time it takes for physicians and patients to connect with a care coordinator and receive requested community services.
- Increase the number of HSPs that have developed and implemented Quality Improvement Plans from current levels, according to the provincial roll-out timeframes
- Increase the number of HSPs from the community sector that are accredited from current levels.

Risks/Barriers to Successful Intervention

Risk	Mitigation Strategy
Provincial and regional stakeholders may face competing demands, duplication or inconsistency related to initiatives designed to support quality improvement.	• The Central West LHIN Quality Framework will be disseminated LHIN-wide to all relevant stakeholders. The LHIN will also consult with HSPs and stakeholders on opportunities for greater alignment and collaboration on quality objectives and priorities.
Variation in the capacity of HSPs to commit the required time and resources at governance, clinical and administrative leadership and front-line levels to drive improvements in quality.	• The Central West LHIN will work with HSPs with limited support to develop strategies for increasing capacity for quality improvement and facilitate uptake of provincial training and coaching support including application of Central West LHIN teams to IDEAS and associated projects.

For some smaller HSPs, completion of accreditation may require resources that exceed their capacity (i.e., lack of funding, human resources).	▪ The Central West LHIN will work with HSPs to support accreditation efforts including review of funding requests and support for strategies that build organizational capacity for the completion of the accreditation process.

Key Enablers

The Central West LHIN will drive improvement in quality and safety through the development of an overarching framework for quality. To do so, collaboration, alignment and coordination of provincial and regional strategies among the Central West LHIN, the Board of Directors and funded agencies are needed to optimize the impact of improvement efforts. Expertise, resources, the sharing of best practices and acknowledgement of success are necessary to advance a culture of continuous quality improvement.

2.9 Optimize Use of Health Care Resources to Foster Better Value

IHSP Initiative Description

When people are admitted to hospital unnecessarily or are designated Alternate Level of Care (ALC) while occupying hospital beds, they are by definition not receiving the right care in the right place at the right time—these LHIN residents would be better served by receiving the care that they need in other settings, which cost less than avoidable in-hospital care. Because hospitals beds are a scarce resource, not only do these residents not receive the care that they need, but they take up resources that are needed by other LHIN residents, thus driving up wait times throughout the system.

The Central West LHIN is working to reduce these occurrences and provide more appropriate care to all residents by supporting expanded community-based services and by seeking improvements in admission, bed use, and discharge processes. Additionally, the LHIN will implement HSFR initiatives with the MOHLTC and local HSPs to support best practice, cost-effective treatment and care.

Current Status

The Central West LHIN has the highest proportion of high-acuity ED visits in the province. In 2014/15, 81% of all ED visits were triaged as high acuity, compared to 68% for the province. 13% of all ED visits and 16% of the high acuity ED visits resulted in an inpatient admission. The LHIN has met provincial ED wait time targets for low-acuity patients, discharging 93% of patients within four hours or less of presentation and 93% of high acuity patients within eight hours. These improvements are largely attributable to the Pay for Results program, which was in its seventh year in 2014/15, and targets improvements in the experience of patients being seen in the emergency department.

Patient flow through the rest of hospitals in the Central West LHIN still has room for improvement. Patients whose ED care results in admission to an inpatient bed continue to wait too long in local emergency departments. The average length of stay for these patients in 2014/15 was 16 hours, and 1 in 10 patients waited 26 hours or more from the time the decision was made to admit them until they were assigned an inpatient bed.

The number of patients processed through the system without being designated as ALC continues to increase, while the number of patients being discharged with an ALC designation is declining. In 2014/15, 1,777 patients were designated ALC in the Central West LHIN. 1,508 ALC-designated patients were discharged, accumulating a total of 22,289 ALC days. Although the Central West LHIN maintains one of the lowest rates of inpatient capacity lost to ALC, work continues toward reducing ALC designations.

A focus of the Patient Flow Core Action Group at the Central West LHIN is to reduce avoidable hospital admissions from both EDs to inpatient units and from acute to post-acute beds. A proxy measure to track these admissions is ALC designations within two days. There are few conditions which require a hospital stay of two days or less. These tend to be relatively routine

episodes of care for young and healthy people, such as childbirth or minor surgeries, and those conditions are much more likely to result in an unfettered discharge. When a patient is designated ALC within two days of having been admitted to an inpatient bed, there is a strong likelihood that the admission was not clinically necessary. The rate of patients designated ALC within two days has been variable over the past four years, but hit a low of 11% in Q2 of 2014/15, reflecting success in reducing unnecessary admissions.

In 2013/14, funding for selected surgeries and diagnostic wait times shifted to the new QBP model. Providers are expected to deliver these procedures within funded amounts while maintaining and improving access times. The LHIN has experienced tremendous improvement in wait times for diagnostic imaging—more than 90% receive computerized tomography (CT) within the provincial access target of 28 days. For magnetic resonance imaging (MRI), the Central West LHIN has moved from rates below 20% in 2010 and 2011, to performance above 80% in 2013/14. More than 90% of cancer surgeries and close to 90% of cataract surgeries are consistently performed within provincial access targets. However, wait times for hip and knee replacement continue to grow and the number of residents receiving these surgeries within the provincial access target continues to decline. The LHIN has worked with its hospitals to improve performance, but the overwhelming demand for these procedures continues to outstrip the supply.

Health System Funding Reform

In March 2013, the Central West LHIN, working with hospitals, the Central West CCAC and LTC Home partners, launched the Central West Health System Funding Reform Local Partnership (Central West HSFRLP). Local Partnerships were created in each of the 14 LHINs to support provincial HSFR goals and objectives: patient-based funding strategies aligned to the needs of the community with a focus on better quality care and improved outcomes. Over the course of the last two years, the Local Partnership membership has collaborated on implementing HSFR aligned strategies – QBP allocation/funding and locally lead QBP practice engagement and implementation.

In addition, HSPs in the Central West LHIN are participating in the MOHLTC provincial applied learning strategy IDEAS - Improving & Driving Excellence Across Sectors - designed to enhance quality improvement and change leadership capacity as a foundational component of its transformation agenda. A pilot project focused on COPD was completed and a second focused on Orthopedics is currently underway.

In November 2014, the MOHLTC met with the Central West HSFRLP as part of a provincial engagement strategy to discuss local HSFR issues and opportunities and provide an overview of a broader quality strategy and HSFR. In 2015/16 the Central West HSFRLP will continue to support the implementation of the HSFR strategy both provincially and locally and will continued to work with the MOHLTC and HSPs in the Central West LHIN to strengthen the alignment of local needs with the HSFR agenda.

Health Service Provider Performance Monitoring

In 2014/15, the Central West LHIN completed the development of a Service Accountability Agreement (SAA) Dashboard, with the intent to monitor HSP compliance with their respective SAA for all three sectors (hospital, community, LTC homes). The dashboard presents information on financial status, volume of service delivery, performance indicators, and compliance to action items outlined in the SAAs. Moving forward, the LHIN will continue to monitor the financial and service delivery obligations of HSPs. This dashboard will be presented to the Central West LHIN Board of Directors Finance and Audit Committee on a quarterly basis.

Alignment with Government Priorities

Ontario's *Patients First*: Action Plan for Health Care focuses on providing the right care, in the right place and at the right time and the objectives of Ministers' Mandate Letters relate to driving a sustainable, accountable and quality health care system. Preventing avoidable hospital admissions is better quality care. By doing so, the Central West LHIN improves resource allocation and adds value to the system. Reduction of ALC has been a provincial priority since launch of the provincial ER/ALC

strategy in 2009. Improving patient flow and reducing barriers to discharge result in more patients receiving the care they need, when and where they need it.

Action Plans/Interventions	2015/16	2016/17	2017/18
Develop and align the Patient Flow Core Action Group's work plan on initiatives to optimize patient flow with measurable outcomes.	In Progress 40%	Complete	Complete
Implement Health System Funding Reform Local Partnership.	100%	Ongoing	Ongoing
Ensure local alignment to Provincial HSFR roll-out.	In Progress 50%	Ongoing	Ongoing
Create a multi-phased capacity plan by sector, using a demographic and evidenced based methodology.	In Progress 75%	25%	Complete

Expected Impacts of Key Action Items

By the end of 2015/2016, more residents will be admitted from local emergency departments within Ontario's wait time targets. Fewer residents will receive ALC designations during their hospitalization.

Outcome Metrics:

- Meet MLPA targets for emergency department length of stay.[1]
- Meet MLPA target for percentage of ALC days experienced by patients discharged from acute inpatient beds.[1]
- Reduce the rate of ALC designation within 2 days to 10% by 2014/2015.[1]
- Meet MLPA targets for QBP wait time indicators.[2]
- Maintain best practice recommendations for average LOS for hip/knee replacement patients discharged home.[2]

[1] WTIS
[2] DAD: through CIHI portal

Risks/Barriers to Successful Intervention

Risk	Mitigation Strategy
Hard-to-place clients are a contributing factor to increasing lengths of stay in regard to ALC designations. Referrals are reportedly denied into Long-Term Care due to "behavioural characteristics".	▪ The Central West LHIN will work with the MOHLTC and local providers to identify opportunities to address access gaps and increase capacity. ▪ Support ongoing use and growth for the Behavioural Supports Ontario (BSO) program. ▪ Using findings from the Seniors Community Capacity Study, the LHIN will evaluate the need to increase Assess and Restore beds and community funding.
HSPs do not achieve performance targets agreed to in their Accountability Agreements.	▪ The Central West LHIN commits to regular meetings and quarterly review of HSP performance to monitor progress and understand current state. The LHIN is developing a performance management framework to monitor and intervene on performance. ▪ Where needed, HSPs will be asked to develop and implement a Performance Improvement Plan that focuses on the risks of non-performance and problem-solving.

Key Enablers

Clear identification of processes, objectives, timelines, and accountabilities are essential to preventing hospital admissions. Sufficient time and resources allocated for staff engagement, training, and internalization will optimize the impact of improvement efforts. Local understanding and expertise of HSFR processes are needed to successfully implement local funding reform.

Build On the Momentum

IHSP Initiative Description

The Central West LHIN continues to devote time, attention and resources to long-standing initiatives, in keeping with the LHIN's legislated requirements, that are identified through community engagement and priority-setting. These initiatives are aligned with developing provincial directions and priorities.

Aboriginal Health

The Central West LHIN will continue to engage local Aboriginal and First Nations peoples with the aim of better understanding local health and service delivery issues so as to further develop priorities and strategies to improve access to and engagement of health care services.

Diversity and Health Equity

The Central West LHIN is working with local HSPs at the Diversity and Health Equity Core Action Group to identify specific local strategies to engage the diverse communities in the LHIN and to promote equitable access to health care services. This work includes identifying key priorities for action, using tools such as the Health Equity Environmental Scan, the Health Equity Impact Assessment Tool (HEIA), Health Equity Plans, and leveraging cultural competent training modules to improve access to, and the quality of, health care services.

French Language Services

The Central West LHIN will continue to engage local French-speaking communities by working in collaboration with Reflet Salvéo, the French Language Health Planning Entity, with the aim of improving access to and integration of French language health care services in the local health care system.

Palliative Care Services

Along with LHINs across the province and the Ministry of Health and Long-Term Care, and working locally with the Central West Palliative Care Network, the Central West LHIN is participating in the development of the vision for palliative care in the province. The LHIN is establishing a local plan for palliative care services, tailored to meet the needs of residents with palliative needs and their families.

Women and Children's Health

The Central West LHIN is working with local providers to improve the quality of, and access to, women and children's health services, while at the same time aligning its work with provincial initiatives. The LHIN is primarily focused on improving access to and coordination of services for children with special needs and children with medical complexities.

Current Status

Aboriginal Health

Members of the Aboriginal community access services through mainstream providers within the Central West LHIN, or travel to Toronto to seek culturally-sensitive services through Anishnawbe Health. In 2014/2015 the LHIN partnered with the Credit River Métis Council in the planning of the Sisters in Spirit Vigil, a traditional Métis medicine walk and a Board and staff Métis information and training session. In addition, select staff completed the Indigenous Cultural Competency training program. Indigenous Cultural Competency training for HSPs, delivered through 8 hours of online training, is being planned for 2015/16.

Diversity and Health Equity

The Central West LHIN is an ethno culturally diverse community and a region of increasing income disparity. These characteristics have significant implications for the health of the local population and the health care system. When either groups and/or individuals face barriers to access and receive a lower standard of care, this leads to poorer health, greater strain on limited healthcare resources and ultimately higher costs for worse outcomes.

To date, the LHIN has introduced use of the Health Equity Impact Assessment (HEIA) tool to funded agencies by partnering with the MOHLTC and the Regional Diversity Roundtable. HSPs are using this tool to improve program planning for marginalized populations. In addition, the Central West LHIN Health Equity Core Action endorsed the use of a cultural competence training module created by SickKids, and funded by Citizenship Immigration Canada. Use of these modules is being integrated into educational curriculum at acute care hospitals. This year acute care hospitals and community sector providers submitted Health Equity Plans that are currently being reviewed by the LHIN. There is an expectation that yearly progress reports on an organization's implementation of the plans are provided to the LHIN. Initial review of the plans indicates a gap in the collection of patients' socio-demographic information which makes it difficult to identify key structural and client service barriers that may hinder the provision of optimal care for the residents in the Central West LHIN.

French Language Services

The LHIN's French Language Services Core Action Group has provided a forum for identified French Language Services (FLS) HSPs to engage in the execution of their Yearly Implementation Plans, for the development of French language services. In 2015/16 there will be a specific focus on incorporating the new Self-Reporting Initiative based FLS report, and expanding French language service initiatives to non-identified FLS HSPs. The LHIN continues to work closely and collaboratively with Reflet Salvéo on engaging the francophone community, capacity building and service planning. Priorities and actions are identified and outlined in a Joint Annual Action Plan between Reflet Salvéo and the Central West, Mississauga Halton and Toronto Central LHINs. Year-end reporting by each identified for French language services HSP has indicated an increase in the number of Francophone residents who requested and were served in French.

In 2015/16, the Central West LHIN will focus on advancing health equity initiatives and FLS by engaging with the Central West LHIN's Core Action Groups, community stakeholders, HSPs and local residents to develop equity strategies that will reduce barriers to access and ensure all residents receive a high standard of care. By adopting an equity lens in service planning and delivery, the LHIN is committed to ensuring the needs of and impacts on all groups and communities are considered.

Palliative Care Services

The Central West Palliative Care Network provides a community for the advancement of hospice palliative care. Network members benefit from a system of communications, strategic planning, and education through a Steering Committee and advisory groups. Members represent hospice palliative care, hospital, Long-Term Care, primary care, community care and education sectors.

In 2013/14, the Shared Care Model of Palliative Care was enhanced through the addition of two part time medical directors, two additional nurse practitioners and two psychosocial spiritual care coordinators. This group of health professionals is

available to consult with primary care providers and health service providers on palliative care patients. The Shared Care Team collectively served 821 unique individuals and delivered 2765 units of service in 2013/2014. That same year, the palliative shared care nurses diverted 392 palliative patients from visiting local emergency departments.

The William Osler Health System named a medical director for its palliative care programs and reconfigured its inpatient program. In the summer of 2014, two new palliative care outpatient clinics were opened at each of the Etobicoke General and Brampton Civic Hospital sites. The Community Capacity Study projected the need for end-of-life care spaces (e.g. hospice beds, inpatient beds) over the next two decades.

The Central West LHIN was one of three LHINs chosen for a value for money audit by the Office of the Auditor General of Ontario in 2014. The results of the audit along with the Ministry's Declaration Document, Community Capacity Study, Ministers' mandate letters, and local HSPs working in partnership will drive the work of the Central West Palliative Care Network.

Women and Children's Health

The Central West LHIN works with the Provincial Council for Maternal Child Health (PCMCH) to improve access to care for children with medical complexities. The LHIN is also currently involved in the development of the local Special Needs Strategy for Peel and Dufferin in alignment with a provincial strategy to improve services for children and youth with special needs in Ontario. This requires working with providers that are funded by the Ministry of Children and Youth Services (MCYS), Community and Social Services (MCSS), Education (EDU) and MOHLTC.

Ontario's Better Outcomes Registry and Network (BORN) data for 2012-13 indicates that the breastfeeding initiation rate for Ontario was 88%, and that the rate of exclusive breastfeeding declined to about 60% by discharge. The goal is to increase this rate and strive to achieve almost 100% in breastfeeding initiation rate. To this end, the LHIN is supporting the provincial Baby-Friendly Initiative (BFI) strategy with an expectation that more organizations funded by the Central West LHIN will be BFI designated.

Alignment with Government Priorities

Addressing health equity is a key strategy for improving the health of the population and the communities in which they live. The Central West LHIN recognizes the culturally diverse and disadvantaged populations it serves and will ensure a Health Equity perspective is built into the planning, funding and implementation of programs. This commitment to health equity is in alignment with the objectives of the MOHLTC's strategic direction of equity of access, outlined in the *Local Health System Integration Act (LHSIA)*.

The LHIN provides services to the public in French in accordance with the *French Language Services Act (FLSA)*. In addition, the *Local Health System Integration Act (LHSIA)* sets out obligations for the LHIN to engage Francophones to inform health system priorities, actions and performance indicators. FLS planning entities play a critical role in advising Ontario LHINs regarding local FLS needs and priorities.

Planning for the local needs of Aboriginal communities will build upon work being done at the provincial level, including the development of the Aboriginal and First Nations Health Council, the provincial Aboriginal Wellness Strategy, the Aboriginal Diabetes Strategy and the Provincial Aboriginal Leads Network's Annual Action Plan.

The objectives of the Central West Palliative Care Network are aligned with the standards detailed in the Ministry of Health and Long Term Care document: *"Advancing High Quality, High Value Palliative Care in Ontario, Declaration of Partnership and Commitment to Action"* (2011). Members of the Central West Palliative Care Network play active roles on the Hospice Palliative Care Provincial Steering Committee and its sub committees. The findings of the Auditor General and Health Quality Ontario were released in December 2014 and will be incorporated the work plans of the Central West Palliative Care Network.

The goals and objectives of the local special needs strategy for children in Peel and Dufferin are in alignment with the MOHLTC's and three other Ministries' (the Ministry of Education, Ministry of Children and Youth Service and the Ministry of Community and Social Services) aims to improve coordination of services and rehabilitation services in the province.

Action Plans/Interventions	2015/16	2016/17	2017/18
Monitor HSPs progress on their Health Equity Plans through year end reports.	100%	Ongoing	Ongoing
Engage HSPs to effectively use the Over the Phone Language Interpretation service provided by University Health Network (UHN)	In Progress 100%	Ongoing	Ongoing
In collaboration with Reflet Salvéo and partnering LHINs, implement Central West LHIN specific action items from the FLS Joint Annual Action Plan.	In Progress 100%	Ongoing	Ongoing
Develop FLS capacity in Central West LHIN HSPs through an enhanced active offer of services, building on bilingual health human resources as identified in the Yearly Implementation Plans of the four "identified" providers.	In Progress 33%	33%	Ongoing
Engage local Aboriginal and First Nations community in a minimum of three activities per year.	In Progress 33%	33%	Ongoing
Develop a plan to make an Indigenous cultural competency training program available to HSPs	100%	Complete	Complete
Develop a work plan for the local response to the Auditor General's report on Palliative Care and align the Central West Palliative Care Network to the LHIN's vision of improved, integrated palliative care in the Central West LHIN.	100%	Complete	Complete
Participates in local special needs strategy planning tables, to develop and support plans for submission to Ministries.	100%	Complete	Complete

Expected Impacts of Key Action Items

In providing services through a Health Equity lens, we will achieve better access, better value and better quality of care for all residents in the Central West LHIN.

Outcome Metrics:

- Increase compliance with and reporting of Local Indicators for French Language Service requirements; Health Equity Plans; Palliative Care; and Woman/Children's Health among funded Health Service Providers as specified in their Service Accountability Agreements (SAAs). [1]
- Monitor the proportion of Francophone and Aboriginal Peoples reporting access to a regular medical doctor.
- Establish a baseline and target to reduce the total number of hospital days that are attributed to palliative care. [2]
- Increase the number of emergency department visits averted for community-based palliative patients by 5% by 2015/2016.

[1] HSP Supplemental Reporting | [2] DAD: through CIHI portal

Risks/Barriers to Successful Intervention

Risk	Mitigation Strategy
Lack of reliable data on the use of health care services by members of specific communities limits local knowledge of service use among diverse populations.	▪ The Central West LHIN will focus on monitoring and tracking available data that captures residents' access to and use of services by race, culture, language and gender. ▪ Central West LHIN staff will continue to work with its counterparts at the local and provincial level to determine challenges and opportunities for collecting data that encompasses information about race, culture, language and gender.

Service and resource pressures driven by population growth may deflect attention away from specific needs of high-risk communities.	▪ All of the Central West LHIN Core Action Groups will continue to display an understanding of and explore challenges and opportunities to improve access to culturally competent care for marginalized, disadvantaged, and hard-to-reach residents of the LHIN.

Key Enablers

Building on relationships established with the Central West LHIN Core Action Groups, local Aboriginal communities and the Palliative Care Network, the Central West LHIN and its Board of Directors will continue to provide support and improve services for these priority populations. Strong leadership will enhance cooperation and engagement amongst the diverse partners and active participation and inclusion amongst the LHIN in locally hosted activities will allow us to learn from our peers, adopt best practices and deliver culturally-sensitive, compassionate services to residents.

SECTION 3 | Financial Plan: Operations & Staffing

3.1 Three-Year LHIN Operations Spending Plan

LHIN Operations Spending Plan						
LHIN Operations Sub-Category ($)	**2013/14 Allocation**	**2013/14 Actuals**	**2014/15 Actuals**	**2015/16 Planned Expenses**	**2016/17 Planned Expenses**	**2017/18 Planned Expenses**
Salaries and Wages	2,304,489	2,258,019	2,405,407	2,383,473	2,416,936	2,447,784
EMPLOYEE BENEFITS						
HOOPP	230,449	220,090	237,698	238,347	241,694	244,778
Other Benefits	253,495	225,376	265,085	262,182	265,863	269,256
Total Employee Benefits	***483,944***	***445,466***	***502,783***	***500,529***	***507,557***	***514,035***
TRANSPORTATION AND COMMUNICATION						
Staff Travel	30,000	13,671	14,604	15,000	15,000	15,000
Governance Travel	20,000	14,814	10,978	20,000	20,000	20,000
Communications	77,000	65,222	41,032	75,000	75,000	75,000
Other	-	37,723	3,495	-	-	-
Total Transportation and Communication	***127,000***	***141,430***	***70,109***	***110,000***	***110,000***	***110,000***
SERVICES						
Accommodation	240,000	239,781	234,812	184,000	184,000	184,000
Advertising	20,000	3,192	17,015	20,000	20,000	20,000
Banking	100	148	123	100	100	100
Consulting Fees	182,695	197,661	100,859	253,141	212,650	175,324
Equipment Rentals	9,000	8,173	8,100	8,000	8,000	8,000
Insurance	7,000	6,231	6,749	7,000	7,000	7,000
LSSO Shared Costs	342,000	434,607	328,153	285,344	285,344	285,344
LHIN Collaborative	47,500	47,500	39,018	34,141	34,141	34,141
Other Meeting Expenses	25,000	21,022	33,710	20,000	20,000	20,000
Board Chair's Per Diem Expenses	72,800	66,850	48,300	72,800	72,800	72,800
Other Board Members' Per Diem Expenses	92,300	67,225	57,600	92,300	92,300	92,300
Other Governance Costs	30,000	44,201	39,375	30,000	30,000	30,000
Printing and Translation	57,000	21,751	33,901	50,000	50,000	50,000
Staff Development	46,000	42,385	38,591	46,000	46,000	46,000
Total Services	***1,171,395***	***1,200,728***	***986,306***	***1,102,826***	***1,062,335***	***1,025,009***

IT Equipment	20,000	13,424	36,855	20,000	20,000	20,000
Office Supplies & Purchased Equipment	50,000	53,405	82,655	45,000	45,000	45,000
Total Supplies and Equipment	***70,000***	***66,829***	***119,510***	***65,000***	***65,000***	***65,000***
Capital Expenditures	25,000	8,900	51,037	20,000	20,000	20,000
LHIN Operations: Total Planned Expense	**4,181,828**	**4,111,373**	**4,135,152**	**4,181,828**	**4,181,828**	**4,181,828**
Annual Funding Target	4,181,828	4,181,828	4,181,828	4,181,828	4,181,828	4,181,828
Surplus	-	70,455	46,676	-	-	-
INITIATIVES SPECIFIC FUNDING						
French Language Services	106,000	78,367	104,870	106,000	106,000	106,000
Annual Funding Target	106,000	106,000	106,000	106,000	106,000	106,000
French Language Services Surplus	-	27,633	1,130	-	-	-
Diabetes Regional Coordination Centre	856,301	527,715	728,517	856,301	856,301	856,301
Annual Funding Target	856,301	529,223	781,301	856,301	856,301	856,301
Diabetes Regional Coordination Centre Surplus	-	1,508	52,784	-	-	-
Aboriginal Community Engagement	7,500	1,717	6,610	7,500	7,500	7,500
Annual Funding Target	7,500	7,500	7,500	7,500	7,500	7,500
Aboriginal Community Engagement Surplus	-	5,783	890	-	-	-
ER/ALC, Performance Lead	100,000	100,000	100,000	100,000	100,000	100,000
Annual Funding Target	100,000	100,000	100,000	100,000	100,000	100,000
ER/ALC, Performance Lead Surplus	-	-	-	-	-	-

3.2 Three-Year LHIN Staffing Plan

Staffing						
Position Title	2013/14 Allocation FTEs	2013/14 Actuals FTEs	2014/15 Actuals FTEs	2015/16 Forecast FTEs	2016/17 Forecast FTEs	2017/18 Forecast FTEs
1. Administrative Assistant, Diabetes Regional Coordination Centre	1	1	1	1	1	1
2. Administrative Assistant, Health System Integration	1	1	1	1	1	1
3. Administrative Assistant, Health System Performance	1	1	1	1	1	1
4. Board and CEO Liaison	1	1	1	1	1	1
5. CEO	1	1	1	1	1	1
6. Director, Communication and Community Engagement	1	1	1	1	1	1
7. Director, ER/ALC/Decision Support	1	1	1	1	1	1
8. Director, Funding and Allocation	2	2	2	2	2	2
9. Director, Health System Integration	4	4	4	4	4	4
10. Director, Health System Integration, Diabetes Regional Coordination Centre	1	1	1	1	1	1
11. Director, Performance & Accountability	1	1	1	1	1	1
12. Director, Quality	1	1	1	1	1	1
13. Executive Assistant	2	2	2	2	2	2
14. French Language Services Coordinator and Aboriginal Health Consultant	1	1	1	1	1	1
15. Health System Integration Specialist, Diabetes Regional Coordination Centre	1	1	1	1	1	1
16. Health System Integration and Quality Improvement Specialist, Diabetes Regional Coordination Centre	1	1	1	1	1	1
17. LHIN Operations Manager	1	1	1	1	1	1
18. Senior Director, Health System Integration	1	1	1	1	1	1
19. Senior Director, Health System Performance	1	1	1	1	1	1
20. Specialist, Decision Support	1	1	1	1	1	1
21. Specialist, Decision Support, Diabetes Regional Coordination Centre	1	1	1	1	1	1
22. Specialist, Performance	1	1	1	1	1	1
23. Specialist, Performance & Integration	1	1	1	1	1	1
24. Specialist, Performance & Quality	1	1	1	1	1	1
Total FTEs	**29**	**29**	**29**	**29**	**29**	**29**

SECTION 4 | Communications & Community Engagement

Ontario's health care system has evolved to a point where LHINs are recognized for their leadership role in driving local health system transformation. Consequently, with the *Patients First*: Action Plan for Health Care and Ministers' Mandate Letters as a guide, the Central West LHIN has a critical role to play in moving key provincial initiatives forward including Health Links, HSFR, health initiatives for seniors, and the expansion of Quality Improvement Plans (QIPs) into the primary care, community and Long-Term Care sectors.

The following outline will be used to guide the communications and community engagement activities of the Central West LHIN Board of Directors and staff in support of IHSP 3 and ABP 2015/16.

Business Objectives

- Improve access to care
- Streamline transitions and navigation of the system
- Drive quality and value
- Build on the momentum

Communication Objectives

- Educate and build broad stakeholder awareness of Central West LHIN strategic imperatives and priorities identified in IHSP 3 (above noted business objectives).
- Foster an understanding of the need for continued health system transformation.
- Build ongoing support for an integrated sustainable local health care system that ensures better health, better care and better value for LHIN residents.
- Raise awareness of the Central West LHIN's role, its unique characteristics, value proposition, caliber and credibility of work, and importance within the local health care system.
- Educate and build awareness among HSPs regarding shared accountability for local health system transformation and the alignment of their respective /initiatives with IHSP 3.
- Continue to build strong, trusted relationships with HSP communications teams across the Central West LHIN, working together to optimize communication resources and coordinated services.

Stakeholders

Depending on the situation, primary and/or secondary stakeholders (audiences) will include:

- General Public
  - Residents
  - Community Organizations
- Health Service Providers, Health Care Professionals, community partners and, as appropriate, surrounding LHINs:
  - Leadership, Front Line Staff and Boards of Directors as required
  - Physicians, clinicians, health care professionals, caregivers (paid /unpaid)
  - Patients/Clients/Consumers/Residents
  - Consumer/Patient Support Groups

  - Healthcare Associations (OHA, ONA, OMA, etc.)
- Government
  - Municipal
  - Regional
  - Provincial (including Ministry of Health and Long-Term Care, other ministries as appropriate)
  - Federal
- Media
- LHINs

Strategic Approach

- Position the LHIN as a valued partner in the transformation of Ontario's health system.
- Position the LHIN as the leader of localized health system transformation.
- Position the work of the LHIN and local HSPs as a comprehensive and meaningful redesign of the way by which local health care needs are being heard, understood, addressed and met.
- Position the work of the LHIN as a model for "Healthy Change" that successfully breaks down barriers, encourages collaborative work, shares knowledge and fosters partnerships among local, regional and provincial agencies.
- Develop and leverage opportunities to build the reputation and establish credibility of the Central West LHIN.
- Ensure that effective Community Engagement and input takes place at the most appropriate juncture(s) of a program or operational planning process that requires careful and comprehensive public consultation.

Tactics

- **Media -** In an effort to reach a variety of audiences, the Central West LHIN will seek to maintain and build upon existing relationships, while exploring new channels where deemed appropriate.
  - **Print:** When and as required, the Central West LHIN will issue appropriate and timely news releases, opinion editorials and matte stories to educate and inform communities regarding the current happenings and goings on the local health care system.
  - **Broadcast:** The LHIN will look at opportunities to formalize its presence on television and radio platforms.
  - **Social / Online:** The Central West LHIN will look to formalize its presence with online/social media by devoting time and resources to establishing a formal social media policy, effectively managing new and existing content and committing to the development and use of interactive video content.
  - **Publications:** While the LHIN will continue to design and publish regular, targeted newsletters to a variety of stakeholders, their number, frequency and method of delivery will be reviewed to ensure they are meeting the needs of the intended audiences.

- **Stakeholder Events -** Whenever possible, the Central West LHIN Board and/or Staff will participate in stakeholder engagement opportunities including but not limited to in-person town halls, telephone town halls, partner events, sponsored events, ground breaking ceremonies, facility openings, funding announcements, program/initiative announcements, media opportunities etc.

- **Industry and Public Events/Conferences** – When and where deemed appropriate, the Central West LHIN Board of Directors and Staff will continue to participate in key public health fairs and conferences at which they will have the opportunity to showcase LHIN activities, programs, achievements and successes.

- **Regional and Municipal Councils, and MPP Contact** - The LHIN will continue to meet regularly and communicate with regional, municipal and civic councils and MPPs across the area, to update them on achievements at the LHIN and to provide context on how work being done might impact their specific constituencies.

- **Brand Leveraging** – As local residents experience their health care system through their Health Service Providers, the Central West LHIN will seek to further leverage the brands and communication channels of key partners in order to more effectively deliver LHIN messages and information to local residents.

Key Messages

While different situations and issues will require specific messaging appropriate to the circumstances in which they arise, overall key messages should be adopted throughout the Central West LHIN's Communications & Community Engagement Plan. They include:

➢ Health System Transformation Messages

The Ministry of Health and Long-Term Care is...

- Putting people and patients first by enhancing the health care experience.
- Providing information to make decisions, and tools to live healthy and stay healthy.
- Providing better access to quality health services, and protecting those services for generations to come.
- Providing faster access to the right care.
- Providing enhanced home and community care.
- Providing information to make the right decisions about your health.
- Ensuring our universal health care system is sustainable for generations to come.

➢ Local LHIN Messages

The Central West LHIN has a strategic and operational plan to ensure local residents have access to high quality, localized care, and a sustainable health care system for years to come.

- By organizing the system differently and focusing on the medical evidence, the LHIN provides local residents with better care, better health and better value for their tax dollars.

- The Central West LHIN recognizes that the system looks different in the communities across the area. The LHIN builds on these differences because they reflect the diverse needs of local communities.

Together with local partners, the Central West LHIN continues to bring about significant and positive change to ensure better patient outcomes.

- The Central West LHIN maintains Accountability and Performance agreements with the Ministry and local HSP's. These agreements outline in detail, targets to be achieved within agreed time frames to ensure that the quality of care for residents in the LHIN is maintained to the highest-possible standards.

- Bringing together local HSPs around the same table has been a critical step in creating a common vision of achieving a system that is built around patients and their communities, not providers themselves.

The Central West LHIN is committed to building a more seamless and coordinated approach to patient care.

- Silos, fragmentation, duplication and gaps in service delivery can have a dramatic impact on patient outcomes and people's experience with the health system. This is why the Central West LHIN has made it a strategic priority to streamline transitions and navigation across and throughout the health care system.

The Central West LHIN brings together health care partners, such as hospitals and community-based agencies, to develop innovative, collaborative solutions, and is working with local partners to provide a more coordinated, value-driven health care system that provides improved access to high-quality, localized care, improved wellness and an improved overall patient experience.

- The Health Links initiative is making a difference with its collaborative approach to promotion, awareness and education, in addition to the manner by which residents receive their care. Through increased funding to community services, patients are receiving care at home or in their community instead of a hospital.

The Central West LHIN is improving value in the system by identifying opportunities for local service providers to work better together to reduce duplication and delays, and avoid unnecessary costs.

- Prior to the LHIN, many health care agencies and organizations worked separately in silos that created gaps in which patients were often left frustrated and confused about how and where to get the best care. The Central West LHIN has improved coordination among providers, with an emphasis on transition points, so that patients are transferred more smoothly and effectively from one sector of care to another.

- Through Performance Agreements with the LHIN health service providers in this region are being held accountable for the ways in which they provide quality driven, evidence based health care.

- The Central West LHIN is a leading organization by which Primary Health Care will be strengthened, through the establishment of Health Links and the bolstering of Community-based health care services.

Action Plan

Tactic	Timeline(s)	Responsibility	Context
News Releases	As required, to highlight/promote Central West LHIN activities/events.	Communications	In conjunction with program areas as required.
Success Stories	Support timely/effective impact of good news on appropriate audience(s).	Program Leads	Program areas will "feed" material to Communications.
eNews	Monthly newsletter to a general audience.	Communications	Info and fact-checking by program area.
Community Update	Bi-annual publication to recap and check in on progress made throughout the fiscal year.	Communications	Info and fact-checking by program area.

Tactic	Timeline(s)	Responsibility	Context
MPP / Municipal Briefing Notes (Updates)	Sent to MPP's and Municipal Leaders monthly.	Communications	Fed from monthly CEO update to the Board.
MPP Meetings	Quarterly	Central West LHIN Board Chair and CEO	With support from communications.
G2G Sessions	Quarterly	Communications	Support provided to Board of Directors.
Regional, Municipal, Civic Council Meetings	Meet/present to these bodies regularly, contingent on schedule availability.	Central West LHIN Board Chair and CEO	With support from communications.
Conferences	As appropriate.	Relevant Program Area aligned to topic or theme of event.	None.
Speakers bureau (opportunities)	As appropriate.	CEO, Senior Directors to identify opportunities	Speaking notes supplied by Communications as required.
Board Materials	Ahead of and following monthly Board meetings.	Board and CEO Liaison	None.
Media Outreach – Print, Broadcast, Online	Ongoing	Communications	Participation by program area(s) for background and/or education.
Website – Content Management and Updating	Ongoing	Communications	Preparation and postings of materials to be handled by Program area, with vetting by Communications to ensure messaging content and tone.
FIPPA requests	As required. Timing to align with Legislation requirements.	Communications to manage, with timely input from program areas.	None
MOHLTC Requests for information/analysis	As required. Usually on immediate turnaround.	Communications to coordinate with input from program areas.	None
French Language Services coordination	As required to further Central West LHIN and/or Reflet Salvéo with communications plans.	FLS Coordinator, with assistance from Communications	None

Evaluation

Identifying and tracking communication success factors enables the Central West LHIN to more effectively identify whether communication activities have been successful. Using the following measures, a formal and comprehensive evaluation of the LHIN's communications efforts will be carried out in-house.

- Tone and volume of editorial coverage: this information will be collected and evaluated within a context of transparent disclosure.
- Website traffic: using analytics, pages and specific postings are tracked.
- Evaluate LHIN community engagement by monitoring and measuring tone and volume of traditional media, online/social media (e.g., websites, Twitter) and LHIN communication vehicles (blast emails, bulletins).
- Event participation and feedback.
- Visible senior leadership engagement and support for the communications & community engagement activities associated with the IHSP 3 strategic directions and ABP 2015/2016 initiatives.
- Active participation of LHIN Board Members in support of communications & community engagement.
- A clear understanding, by key stakeholders, of the LHIN"s strategic and operational plans, and how they play a role towards their successful realization.
- The appropriate, early and frequent engagement of HSPs to demonstrate how their ongoing participation impacts successful realization of desired outcomes.
- The level to and frequency by which residents are engaged by and with the Central West LHIN using a variety of instruments, including traditional media, online/social media and LHIN communication vehicles.
- The use of feedback mechanisms and ongoing assessment tools to monitor the effectiveness of communication vehicles and messages.

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Director

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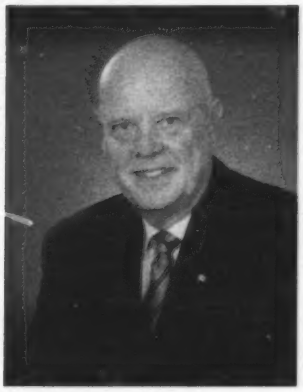
Director

Suzan Hall
Director



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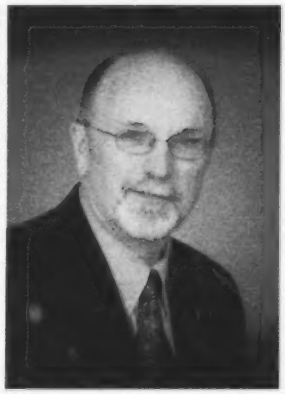

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The Central West LHIN IHSP 4 2016 - 2019 is available in both English and French.